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**Uncertainty and Successful Ageing: The  
perspective from Malaysian middle-aged  
adults using Constructivist Grounded  
Theory**

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Doctor of Philosophy**

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The University of Edinburgh**

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# Declaration

I hereby declare that

- a. This thesis has been composed by myself.
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Vanitha Subramaniam



## **Abstract**

**Background:** Studying the perspectives of middle-aged adults in relation to successful ageing is essential because of significant concern about the growing size of the ‘young old’ population in Malaysia. Growing evidence has highlighted the need to review middle-aged adults’ preparedness for later life, yet research has only been focused on the biographical experiences of ageing selves in older age. Early models of successful ageing (SA) were developed five decades ago and concentrated strongly on diseases and disabilities. Subsequent developments included the importance of psychological, functional, environmental and spiritual elements. However, little attention has been paid to the lay perspective of ageing successfully among middle-aged adults and Eastern populations.

**Aim and Objectives:** This study explores the concept of ‘ageing successfully’ from the perspective of people in middle age, in order to understand the richness and complexity of people’s ‘ageing self’ and how these shapes their understanding of successful ageing in later life. Specifically, this study aims to gain an understanding of the attitudes, normative beliefs and subjective norms that influence one’s intention with regard to successful ageing in the future, and the implications of this for intended behavioural change. This study also focused on the priorities and supports needed to cope with uncertainty that impacts on the ageing experience among the participants.

**Method:** A qualitative study using Constructivist Grounded Theory (CGT) methodology. The data were collected through in-depth interviews with 16 middle-aged adults between 40 and 60 years of age living in Malaysia. These participants met the inclusion criteria of the study and were able to articulate their views about ageing. Heterogeneity of the interviews was maintained in terms of the participants’ gender and marital and health status. The data analysis identified core categories and built a theoretical perspective of ageing successfully that is related to Malaysian adults – leading to the development of the Conceptual Model of Successful Ageing and Uncertainty. The analysis method was consistent with the CGT approach.

**Results:** Uncertainty posed by ‘disruptive events’ in middle age is the key interrupter to achieving successful ageing. Such disruptive events were identified through the primary experiences and incidents encountered by the participants themselves, and also indirectly through the secondary awareness gained through the experiences of other people. The sources of disruptive events are encountered around biomedical factors, personal factors and pressures from socio-economic expectations. The dimensions of uncertainty were influenced by the nature of the disruptive events (e.g. The severity of the impacts, unfulfilled normative expectations and etc.), the knowledge and resources available, assessment by the individual and the input of time. These factors played a significant role in decreasing or increasing the level of uncertainty. The research participants tended to construct their ‘ageing selves’ in the face of adversity, and the coping strategies of ‘being resilient’, ‘building interdependence’, ‘creating balance’ and ‘modifying lifestyles and behaviours’ were developed instinctively to ensure their well-being in older age.

**Conclusion:** The lay views of Malaysian middle-aged adults with regard to ageing successfully are multidimensional and include attainment of certainty in terms of physical and psychological health, spiritual fulfilment, family relationship, independence, financial freedom and having a meaningful life. Resilience through familial and religious understanding is demonstrated to be a key influence on individual behaviour in the face of adversity. There is a need for studies to be conducted in these areas in the future to ensure that middle-aged adults, irrespective of their health status, are exposed to an encouraging environment and are prepared for later life.

## Lay Summary

**Background:** The number of older people in the world's less economically and technologically advanced, developing countries is growing fast, with over half of this growth projected to occur in Asia. The factors contributing to this phenomenon in Malaysia is the country's low birth rate and good standard of health care service that enables increasing numbers of Malaysians to live longer. This phenomenon has raised a significant concern with regard to understanding how people intend to age successfully for comprehensive national plans and policies to enable Malaysian people to have a good old age in the future. However, relatively little work has previously been conducted to explore how people in middle age would like to age in their later life. Early models of successful ageing (SA) were formulated five decades ago and focused heavily on diseases and disabilities. The models developed from thereon included other aspects such as emotional well-being, the support an individual receives from their surroundings, contribution to society, willpower, independence, spirituality and religious practice. Despite its development over the years, the model of successful ageing is still lacking in terms of it providing information on the perspective of lay people in middle age with more studies having been conducted mainly in Western societies.

**Aim and Objectives:** This study explores views on how people aim to age in the future, the behaviours that are needed to achieve this level of ageing and the situations that might prevent and motivate successful ageing.

**Method:** To achieve these aims, this study employed an exploratory method using open questions in order to gain an understanding of the phenomenon. The exploratory method used was 'Constructivist Grounded Theory' (CGT). Through this method, 16 middle-aged Malaysian adults between the ages of 40 and 60 years were interviewed. An equal number of male and female adults, married or single, were recruited and they varied in their health status. The participants identified for this study were also able to communicate their experience regarding ageing.

**Results:** The feeling of uncertainty regarding the future due to the occurrence of unexpected issues during middle age was found to be the main interrupter to ageing

successfully in terms of the way the participants wanted their later life to be shaped. These issues are acknowledged in this study as ‘disruptive events’. While the issues highlighted as ‘disruptive’ were derived from the participants’ own experience, they also relate to certain events that happened to people that they knew and then perceived as potentially happening to themselves. The magnitude of uncertainty was associated with the severity of events (for example, the severity of illness, importance of unmet social expectations and etc.), information and support available to participants, the participants’ own assessment of the impact and how the intensity of uncertainty was shaped over time. The results of this study also indicate that people build their ageing selves through the problems they face and the actions they take to cope them to ensure successful ageing experiences in the future. These coping strategies identified are bouncing back from adversity, creating interdependent with family and society, creating a balance between elements related to ageing successfully and changing lifestyles and behaviours in relation to reducing uncertainty in the long run.

**Conclusion:** To sum up the results, people relate ageing successfully to many layers of factors that contribute to certainty in terms of physical ability, emotional wellness, spiritual needs, family relationships and the ability to perform work and be mobile without requiring the help of others, having enough money and having a purposeful life. The ability to withstand adversity in life through the support provided by family members, society and religious understanding was recognised as an important aspect in achieving successful ageing. There is a need for further study to explore the contribution of these factors to the experience of ageing, both in people who are healthy and in those suffering from health issues so that an encouraging environment for successful ageing is possible.

## **Dedication**

### **‘To my father Subramaniam Thevar who is in heaven’**

Completion of my doctorate was not my dream alone, but it was the purest wish of my late father who believed that I could obtain a PhD and be the first doctorate holder in the family. There is no other person to whom I truly wish to attribute this precious work than to my altruistic father. At a young age, he was forced to stop his schooling to help his father in the paddy fields in India. My father then migrated to Malaysia with my mother, Dhanavalli (my biggest inspiration), at the age of 19. He was unable to get a proper job due to not having an academic qualification, even a permanent job for many years, and he ended up working as a labourer in Malaysia. Despite facing financial difficulties, he provided his five children with an equal opportunity for education and instilled in us the awareness that education is above all other material needs. Forever I shall remain indebted to him for the life he has given me.

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Vanitha Subramaniam



# **Prologue**

## **The journey**

Middle age is an important developmental period in life. An individual's identity is most firmly established during middle age, and with it seeding the attitudes and behaviours of later life. Therefore, understanding the experience of people in this period will contribute to the knowledge of how later life is planned and negotiated.

Therefore, I began this study with the aim of understanding the lay perspective of successful ageing among Malaysian middle-aged adults – a population that has received little attention in the study of SA. The data collection from the Phase 1 interviews highlighted the interesting realisation that the research participants were focused on activities aimed at reducing the uncertainty they faced at the present moment to ensure better ageing in the future. This indication from the Phase 1 data collection later led to further understanding of how these people prepare themselves for the future with having to experience uncertainty resulting from certain disruptive events. The unique differences noticed in the way the research participants cope with uncertainty has yielded information that may be of use in the development of prospective actions by services.

## **Personal reflection**

Being in midlife myself, this study has also brought awareness of ageing into my own perspective. I agree with some of the recent scholars that SA should be a multidimensional model with objective and subjective modalities. Reflecting on my perspective, ageing is a life course development in which my experiences make a difference to how I shape my future perspectives (see Appendix 1). My childhood experience of dealing with the challenges that came with parents who had migrated from a different country, my past resilience over problems faced in adulthood and my present experience in a foreign land have all influenced my perspective on the future. I also realised that I will grow together with the information and experiences shared by the participants in this study.



*“...The immature think that knowledge and action are different, but the wise see them as the same”*

**~The Bhagavad Gita~**



# Table of Contents

<b>Declaration</b> .....	<b>iii</b>
<b>Abstract</b> .....	<b>v</b>
<b>Lay Summary</b> .....	<b>vii</b>
<b>Dedication</b> .....	<b>ix</b>
<b>Acknowledgements</b> .....	<b>xi</b>
<b>Prologue</b> .....	<b>xv</b>
<b>Table of Contents</b> .....	<b>xix</b>
<b>List of Figures</b> .....	<b>xxv</b>
<b>List of Tables</b> .....	<b>xxvii</b>
<b>Chapter 1 : Introduction</b> .....	<b>1</b>
1.1 Appraisal of the study.....	1
1.2 Background and statement of the problem.....	2
1.3 The rise of ageing population .....	5
1.3.1 Global ageing population .....	5
1.3.2 Malaysian ageing population.....	8
1.4 Key Aim of the Investigation .....	10
1.5 Research questions .....	11
1.6 The significance of this study.....	11
1.6.1 The scope of this study .....	12
1.7 Main terms and semantics used in this study .....	13
1.8 Outline of the thesis.....	14
<b>Chapter 2 : Literature Review</b> .....	<b>17</b>
2.1 Database search strategy.....	17
2.2 Key terms in the present study .....	21
2.2.1 Middle age.....	21
2.2.2 Old age .....	22
2.2.3 Ageing .....	25
2.2.4 Successful ageing .....	26
2.2.4.1 Theoretical concept of SA by Robert J. Havighurst (1961).....	27
2.2.4.2 Theoretical concept of SA by John W. Rowe and Robert L. Kahn (1987). 27	
2.2.4.3 Theoretical concept of SA by Paul B. Baltes (1990).....	28
2.2.5 Other terms defining successful ageing.....	29

2.2.5.1	SA from social perspective.....	30
2.2.5.2	SA from functional perspective.....	31
2.3	Critical analyses of the theoretical conceptualisation of SA.....	32
2.3.1	Varying theoretical understandings.....	32
2.3.2	Lay perspective versus clinical perspective.....	33
2.3.3	Gap in knowledge of cultural practices and SA.....	36
2.3.4	SA in the context of life course perspectives.....	36
2.3.5	Perspective on SA in diverse populations.....	37
2.3.6	SA in the context of disadvantage and adversity.....	39
2.3.7	Recent development in spiritual transcendence domains.....	40
2.4	Systematic search of the qualitative exploration of SA among middle-aged adults.....	41
2.4.1	Studies retrieved.....	44
2.5	Uncertainty in middle age.....	56
2.6	Care for the ageing in Malaysia.....	57
2.6.1	National policy for older adults' care.....	57
2.6.2	Legislation pertaining to older people.....	59
2.7	Defining the knowledge gap for policy, intervention and initiatives related to the ageing population.....	60
2.8	Key message.....	61
	<b>Chapter 3 : Methodology.....</b>	<b>63</b>
3.1	Research aim and questions.....	63
3.1.1	Objectives.....	63
3.1.2	Research questions.....	63
3.2	Research design.....	64
3.2.1	Ontology and epistemology of the current study.....	66
3.2.2	Positivism vs. Interpretivism/Constructivism.....	67
3.2.3	Grounded Theory.....	68
3.2.4	Reasons for adopting qualitative design.....	71
3.2.5	Other theoretical influences.....	74
3.2.5.1	Symbolic Interactionism.....	74
3.2.5.2	Theory of planned behaviour (TPB).....	77
3.3	Method.....	80
3.3.1	Sample selection and Adequacy.....	80

3.3.2	Participant recruitment .....	83
3.3.3	Research phases and sample.....	86
3.3.4	Ethics consideration .....	95
3.3.5	Confidentiality of data management .....	96
3.4	Data collection.....	97
3.4.1	Phase 1 interviews .....	98
3.4.2	Phase 2 interviews: Theoretical sampling .....	100
	Activity 1- ‘becoming old’ .....	105
	Activity 2- priorities in SA.....	105
	Activity 3 – coping with uncertainty.....	105
3.4.3	Affirmative actions and dilemmas during data collection.....	106
3.5	Data analysis.....	113
3.5.1	Transcription and translation.....	113
3.5.2	Treatment of literature in Grounded Theory data analysis.....	114
3.5.3	Constant comparison .....	116
3.5.4	Coding .....	117
3.5.5	Theoretical sensitivity linking to memoing and data analysis .....	124
3.5.6	Strategies to enhance rigour .....	129
3.5.6.1	Credibility of data collected .....	129
3.5.6.2	Understanding of social phenomena without preconceived ideas/theories.....	130
3.5.6.3	Triangulation in data collection.....	131
3.5.6.4	Credibility and conformability .....	131
3.5.7	Reflexivity of the researcher .....	132
3.6	Key message.....	134
	<b>Chapter 4 : Ageing and Disruptive Events.....</b>	<b>137</b>
4.1	Background to the findings .....	137
4.2	Perception of ‘ageing’ .....	138
4.2.1	The onset of ‘old age’.....	138
4.2.2	Changes in midlife that influence the ‘ageing selves’ .....	139
4.2.2.1	Internal Changes.....	139
4.2.2.1.1	Shifting health .....	140
4.2.2.1.2	Altering physical capability.....	141
4.2.2.1.3	Maturing .....	143
	Attaining spiritual advancement .....	144

4.2.2.2	External influence: Socio-cultural, regulation and technology .....	145
4.2.2.2.1	Having grandchildren/married children.....	145
4.2.2.2.2	Having shared experience with a chronic illness.....	147
4.2.2.2.3	Regulating self by the effect of retirement policy .....	147
4.2.2.2.4	Having a lack of knowledge of modern technology.....	148
4.3	Identifying uncertainty .....	150
4.3.1	How participants identify disruptive events .....	151
4.4	The sources resulting uncertainty: Expectations from social norms, personal factors and biomedical factors.....	154
4.4.1	Striving for reaching social norms.....	155
4.4.1.1	Sustaining socio-cultural values .....	156
4.4.1.1.1	Ageing with expectation of filial obligation.....	156
4.4.1.1.2	Sensing intergenerational disconnection .....	161
4.4.1.1.3	Gaining social status .....	165
4.4.1.1.4	Becoming successful parents.....	167
4.4.2	Securing meaningfulness .....	171
4.4.3	Disrupting health .....	174
4.4.3.1	Facing unexpected consequences of ill health.....	175
4.4.3.1.1	Becoming dependent due to health issue.....	177
4.4.3.1.2	Having limited lifespan .....	178
4.5	Key message .....	180
<b>Chapter 5 : Uncertainty, Coping Mechanism and Successful Ageing (SA) ..</b>		<b>183</b>
5.1	Dimension of uncertainty and successful ageing .....	183
5.1.1	Severity of disruptive events .....	185
5.1.2	Knowledge and resources.....	188
5.1.3	Assessment of risk by individual.....	189
5.1.4	Input of Time .....	191
5.1.5	Importance of facing uncertainty.....	192
5.2	Constructing self to increase coping behaviours to manage uncertainty.....	193
5.2.1	Being resilient.....	194
5.2.1.1	Forming spiritual strength .....	196
5.2.1.1.1	Accepting adverse conditions – Al-Qadar, fate or Karma.....	198
5.2.1.2	Obtaining socio economic stability .....	201
5.2.1.3	Sustaining physical mobility.....	204

5.2.2	Building interdependence .....	206
5.2.2.1	Developing family connectedness .....	206
5.2.2.1.1	Building good relationships with significant others .....	206
5.2.2.1.2	Building interdependence on family .....	209
5.2.2.2	Reaching out to community connectedness .....	210
5.2.2.3	Seeking counsel .....	212
5.2.3	Creating balance .....	213
5.2.4	Modifying lifestyles and behaviours .....	215
5.2.4.1	Altering previous unhealthy behaviours.....	215
5.2.4.2	Initiating new behaviour for improving health.....	218
5.3	Conceptual Model : Uncertainty and SA .....	219
5.4	Priority of actions for managing uncertainty over time .....	222
5.4.1	Short-term importance.....	222
5.4.2	Medium-term importance.....	223
5.4.3	Long-term importance .....	223
5.4.4	All-time importance .....	224
5.5	Key message.....	226
	<b>Chapter 6 : Discussion.....</b>	<b>227</b>
6.1	Dimension of conceptual model: SA and uncertainty.....	227
6.1.1	Identification of uncertainty .....	228
6.1.2	‘Disruptive events’ resulting uncertainty .....	230
6.1.3	Characteristics of the coping strategies shown by the research participants	233
6.1.4	Absence of biomedical factors as a primary component of SA .....	237
6.1.4.1	SA is coping with disease rather an absence of it .....	238
6.1.4.2	Ageing is associated with potential health issues.....	239
6.1.4.3	People with health issues can also age successfully.....	239
6.1.4.4	Older adults are perceived to adjust to the comorbidity that comes with ageing	240
6.1.4.5	People self-rate their health positively and subject to other conditions ....	241
6.1.4.6	Physical mobility related to living independently .....	242
6.1.5	Coping mechanisms developed to address adversity .....	243
6.1.5.1	Spiritual strength as part of ‘being resilient’ .....	244
6.1.5.1.1	Spiritual resilience .....	245
6.1.5.2	Building interdependence.....	250

6.1.5.2.1	Family connectedness during disruptive events.....	250
6.1.5.2.2	Being a productive contributor in the family.....	253
6.1.5.2.3	Strengthening the family relationship through effective communication 253	
6.1.5.2.4	The influence of social institution in shaping the ageing identity.....	254
6.1.5.2.5	Social engagement and well-being in old age.....	256
6.1.5.3	Lifestyle and behaviour modification.....	260
6.1.5.4	Information availability.....	262
6.1.5.5	Balancing with other components.....	263
6.2	The development of conceptual model in regard to Theory of Planned Behaviour (TBP).....	264
6.2.1	Subjective norms.....	265
6.2.2	Behaviour intention.....	267
6.2.3	Supportive environment to influence perceived behavioural control.....	271
6.3	Key message.....	271
	<b>Chapter 7 : Conclusion.....</b>	<b>273</b>
7.1	Articulation of study findings.....	274
7.1.1	Research objective 1: Perspective of ageing and factors contributing to the construction of the ‘ageing self’.....	274
7.1.2	Research objective 2: the beliefs, societal norms and barriers that influence successful ageing.....	274
7.1.3	Research objective 3: Experience, priorities and support needed to cope with uncertainty.....	277
7.2	Critique of the research.....	278
7.2.1	Strengths.....	278
7.2.2	Limitations.....	279
7.3	Recommendations for future research.....	281
7.4	Implications of this study.....	282
7.4.1	Contribution to existing theory of ageing successfully.....	282
7.4.2	Contribution to policy.....	284
7.4.3	Contribution to Education and Practice.....	285
7.5	Final statement.....	286
	<b>Appendices.....</b>	<b>287</b>
	<b>References.....</b>	<b>347</b>

## List of Figures

Figure 1-1: Distribution of the world's population by age and sex, 2017 .....	8
Figure 2-1: Keywords and terms used in the database search .....	20
Figure 3-1: Overview of the research design .....	64
Figure 3-2: Illustration of the study design based on Charmaz's Grounded Theory (2014a) .....	70
Figure 3-3: Modified from the Theory of Planned Behaviour (Ajzen 1988).....	78
Figure 3-4: Recruitment of participants .....	84
Figure 3-5: Overview of the recruitment of participants and data collection .....	88
Figure 3-6: Flowchart on Theoretical Sampling .....	102
Figure 3-7: Sequence of Theoretical Sampling.....	103
Figure 3-8: Process of focus coding.....	119
Figure 3-9: Proces of categorising data.....	121
Figure 3-10: Process of theoretical coding.....	123
Figure 4-1: Sources of disruptive events.....	154
Figure 5-1: Force of uncertainty and expectation of Successful Ageing (SA) .....	183
Figure 5-2: The scale of uncertainty .....	184
<b>Figure 5-3: Constructing self' as a way to manage uncertainty.....</b>	<b>194</b>
Figure 5-4: Being resilient .....	194
Figure 5-5: Building interdependence.....	206
Figure 5-6: Modifying lifestyles and behaviours .....	215
Figure 5-7: Conceptual Model: Successful Ageing and Uncertainty.....	221
Figure 5-8 : The association between actions towards 'managing uncertainty' in numbers across the timeline of consciousness. ....	225



## List of Tables

Table 2-1: Number of studies retrieved according to search database.....	41
Table 2-2: Eligibility criteria, aim, objectives and review questions of studies included in the search.....	42
Table 2-3: PRISMA flow diagram of the literature search process for Item B in Figure 2-1.....	43
Table 2-4: Overview of the studies identified through the systematic search .....	45
Table 3-1: The characteristics of the study sample .....	90
Table 3-2: Profile of the sixteen middle-aged research participants .....	92
Table 3-3: Proseses of initial coding .....	118
Table 3-4: Example of initial open (line-by-line) coding and focus coding .....	126
Table 3-5: Example of initial coding, focus coding, sub-category and core category .....	128
Table 4-1: The prioritisation of landmarks for ‘becoming old’ by the participants collected during Phase 2 data collection .....	149



## **Abbreviations**

SA	Successful Ageing
TPB	Theory of Planned Behaviour
SWB	Subjective Well-Being
GT	Grounded Theory
CGT	Constructivist Grounded Theory
GMT	Grounded Theory Methodology
WHO	World Health Organisation
DOSM	Department of Statistic Malaysia
UN	United Nations
HSI	Hospital Sultan Ismail
ADL	Activities of Daily Living
IHBR	Institute for Health Behavioural Research
MERC	Medical Research and Ethics Committee
NIH	National Institute of Health
SN	Staff Nurse
SHSS	School of Health in Social Science
SOC	Selection, Optimization and Compensation
ESCAP	Economic and Social Commission for Asia and the Pacific
IU	Intolerance of uncertainty
MWFCD	Ministry of Women, Family and Community Development



# **Chapter 1 : Introduction**

This chapter delineates the purpose of conducting this study. Thus, it details an appraisal of the study to enhance the understanding of the nature of the problem and the significance of the study. Next, it details the epidemiology of an ageing population from both a global and a Malaysian current development context. It also lists and explains the study's aims and research questions. Lastly, the chapter assesses the scope of this research, outlines the principal terms and semantics used in this thesis and ends with an outline of each chapter.

## **1.1 Appraisal of the study**

A large body of research over recent decades has indicated that the study of gerontology focuses on ageing as a positive dimension which involves the older people optimising their gains and potential rather than focusing on their losses (Higgs, et. al., Hyde, et al, 2003). This paradigm shift in the notion of the ageing process introduces the concept of successful ageing (SA) as the opposite to 'normal' or 'usual ageing' that tends to focus on ageing as a loss (Martin et al., 2015; Martin, et al, 2012).

Successful ageing therefore refers to well-being in older age, which includes social and psychological determinants alongside those from medical sciences (Bowling & Dieppe, 2005). The domains that constitute SA have been highly researched in the gerontology field, especially among the elderly, and have also produced paradoxical investigations (Kusumastuti et al., 2016). There has therefore been a lack of empirical studies looking at the course of SA in middle age, particularly in relation to the concept of SA among people from an Eastern background and middle-aged adults. Furthermore, to date, despite an increased interest in SA research, there have only been a handful of research studies conducted among middle-aged adults. As such, this gap in knowledge points to the potential need to embark on this study.

The present study employs qualitative research, with Grounded Theory Methodology (GTM) emerging as an efficient way to understand the process of ageing successfully among middle-aged Malaysian adults and contributing unique learning to this field of knowledge. The present study reveals the ability to cope effectively with an uncertain future as a salient component to achieve SA in later life.

## 1.2 Background and statement of the problem

Malaysia's population is projected to increase in size from 28.6 million people in 2010 to 41.5 million in 2040, but with a decrease in the average population growth rate of 1.1 per cent per year. With the continuous decline in the country's fertility rate combined with increased life expectancy, Malaysia is expected to see an ageing population by 2030, when the percentage of the population aged 60 years and above is set to reach 15 per cent. By 2040 the proportion of the population aged 65 years and above will increase to 14% (DOSM, 2018, MWFC, 2018). While Malaysia's ageing population is inevitable, learning about the determinants that lead to a positive outcome in old age will help to create a holistic approach to sustainable old-age provision for those growing old.

The current study aims to explore midlife experiences for ageing successfully. There is a substantial consensus that middle age is one of the major transition periods in the human life course, marking the entry to older age. This life stage is an active phase within the span of an individual's social role (e.g. Parents, wife, job roles, etc.) (Baltes 1990; Willis, Martin, & Rocke, 2010). It includes new demands and responsibilities, shifts in health and morbidity, the need to cope with loss, the adoption of new lifestyles and, importantly, it sets in place the preparatory foundations upon which an individual's later life will rest (Lachman, 2004; Neugarten, 1968). Middle-aged individuals continue to hold prominent responsibilities compared to both younger and older adults (Willis et al., 2010). Fiske (1979) "deemed the time between 40 and 50 years old to be a period during which an individual enjoys good mental health and it is generally seen as a period of satisfaction in family life ( p. 9)".

An individual's sense of self-identity is also highly developed in the midlife period. Farrell (1981) noted that the middle-aged male is viewed to symbolically replace his father, assume the responsibility of the family, move through a series of adaptations and cope with the social expectations placed upon him to the best of his ability. Middle-aged adults, when compared to young adults and the elderly, are seen as the decision makers in society and as taking responsibility for themselves (Hertzog, 2005; Wahl, 2005). Midlife therefore constitutes an important turning point within the formulation of the 'self', and major social changes occur during the middle years of

life (Neugarten, 1968). Moreover, quality of life is related to the actions taken by an individual to protect their medical and social domains and how they balance up the interaction and relationships between these domains and other influencing factors such as their environment and familial considerations (Institute of Medicine (US) Committee on Health and Behavior, 2001). It is thus during middle age that the promotion of SA should occur and accompany the transitional life events that occur during this period (Baltes, 1990). Subsequently, the perceptions and decisions formed at this stage, before one becomes elderly, may have major influences on an individual's later life (Baltes & Lang, 1997).

At the same time, many age-related developments in midlife are multidimensional. With regard to this, a better understanding of midlife development and its functional meaning for late-life advancement requires a shift from the traditional view that is concerned with age norms and the assumption that midlife is a phase characterised by stability (Martin & Zimprich, 2005). In addition, a number of emotional states in later life such as “sad, downcast moods, frequent tearfulness, recurrent thoughts of death/suicide, diminished interest in pleasurable activities and hobbies, feelings of hopelessness or worthlessness, a sense of life being empty, indecisiveness, lack of initiative, avoidance of social interactions, tend to be underdiagnosed” (Reynolds, Alexopoulos, & Katz, 2002, p. 28). Moreover, a substantial body of evidence supports the notion that depression could be triggered by medical conditions or is a response to physical illness (Engum, 2007; Weintraub, Furlan, & Katz, 2002), environmental circumstances such as loneliness, retirement, bereavement and/or feelings of being unwanted or no longer useful (Cummings, 1998), in addition to negative and positive exchanges with partners and family (Stafford et al., 2011). These factors that can trigger depression in later life could be carried from the experiences and risk factors encountered in midlife (Fiske, 1979). In a one-year prevalence study with a sample of the general population aged over 50 years old in the United States, major depression was estimated to affect 6.6% of the study population and they were likely to require follow-up treatment (Mojtabai & Olfson, 2004). Moreover, Barnes et al. (2012) found the risk of developing vascular dementia in later life to be three times higher in those participants with both midlife and late-life depression compared to those who had only late-life depression. However, in the research literature, the question of the extent of

the role played by specific personality traits (i.e. Individual differences in tendencies to display consistent patterns of feelings and actions) and health functioning in midlife in terms of predicting physical and psychological well-being in old age continues to be debated among researchers (Baek, et al., 2016; Perrig-Chiello, et al., 2009)

Subsequently, this drew the attention of the current study researcher to look at behaviours adopted during middle age, as these will play a role in the construction of one's later life. Although the current study has not been designed with the primary aim of investigating the lifestyle of its participants, it is vital to ascertain the challenges they face in terms of adopting a new lifestyle or modifying an existing one. Having to develop habitual healthy behaviours such as never smoking, moderating alcohol consumption, exercising, and eating a healthy diet over the course of a lifetime can attenuate the increase in successful ageing in the future (Sabia et al., 2012). Furthermore, individuals exhibit variations in terms of how they age successfully, and this is almost certainly affected by a range of cultural and societal factors such as dietary habits and patterns of physical activity (Chong et al., 2006a). Though many of an individual's lifestyle and behaviour choices are established early in life, many of these lifestyle choices also remain modifiable throughout the course of their life. As such, older people practising a healthy lifestyle would lead to less of a burden being placed on the younger generation in terms of financial, medical and physical needs (Selvaratnam & Tin, 2007). Finding the lifestyle antecedent to SA from the viewpoint of middle age will be of benefit in assisting individuals to identify the resources for old age that could be cultivated and developed before they reach this stage of life. There has also been a debate on SA focusing on the management or avoidance of physical decline as opposed to finding ways to make later life into a time of expansion of leisure, personal growth or re-invented self-identity (Phoenix & Sparkes, 2009).

It is apparent that the factors which pose a challenge to SA and how middle-aged individuals strategise their well-being in later life are crucial (Perrig-Chiello et al., 2009). However, very few recent papers have taken an explicitly discursive approach to studying the experience of SA among people in this group (Kusumastuti et al., 2016). In addition, the question of the extent to which specific behaviours and elements of health functioning in midlife mitigate well-being in old age continues to be

controversial (Cloninger, 2005; McCrae, 2002; Perrig-Chiello et al., 2009). This is because, according to a study conducted among nuns, a positive affect in early life may impact not only on life satisfaction in old age but also on one's actual length of life (Danner, Snowdon, & Friesen, 2001). The present study is significant in terms of the way in which it provides a better understanding of how middle-aged adults experience ageing and what determines SA among this demographic group. The current study's endeavour is particularly relevant because middle age is often marked by significant life events. Therefore, knowledge relating to how to approach old age positively from an early period of life onwards will contribute to the gap in existing studies of SA.

Another point in midlife that needs to be addressed, as highlighted by Helson et al. (2009), is the way in which many people experience severe challenges to their subjective well-being (SWB) during this period of their life. There is evidence of a risk of increased vulnerability to the onset of chronic disease and decreasing physical capacity among middle-aged adults (Willis et al., 2010). Some adults are seen to struggle, while others adapt effectively to situations of vulnerability (Helson et al., 2009). Therefore, the study of challenges in midlife will inform the characteristics of people who face these challenges and their use of adaptive resources and how aspects of a middle-aged adult's development might impact the process of SA (Helson et al., 2009). It is therefore significant to address the midlife experiences relating to ageing that encourage SA (Hartman-Stein & Potkanowicz, 2003)

Moreover, the population in Malaysia is uniquely composed of a range of multi-ethnic groups, mainly Bumiputra (Malay and other indigenous groups), Chinese and Indian of different cultural practices, all sharing and living in the same environment. Therefore, the development of an understanding of Malaysian middle-aged adults' perspectives on ageing and their means for ageing successfully is crucial to the development of comprehensive and cohesive social strategies, policies and legislation designed to protect the well-being of all older Malaysians with different fates.

## **1.3 The rise of ageing population**

### **1.3.1 Global ageing population**

There have been fundamental changes to the age structures of populations around the

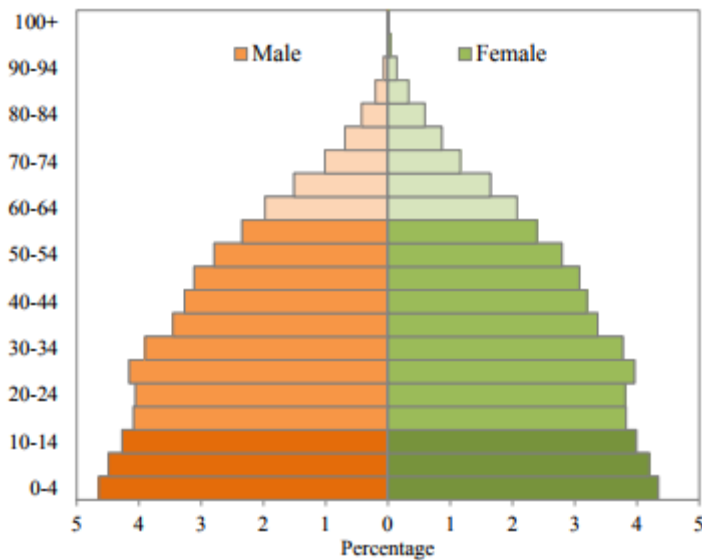
globe. The main reasons for this include low birth rates, increased longevity and significant advances in modern science, alongside other global trends such as urbanisation, globalisation, access to education and female empowerment, and an epidemiological transition to non-communicable disease (World Economic Forum, 2015). Running parallel to these developments has been a significant demographic shift as the proportion of the population rises above a certain age. This phenomenon is known as population ageing and relates to a proliferation in the number of older people throughout the world. There is the potential in the long run for the total number of older people to exceed that of younger individuals, except for in countries where the fertility rate remains high, wherein the population will remain relatively young, at least in the short-term (United Nations, 2015 ).

Although the specifics of this demographic transition differ from country to country, the current figures show a significant difference in age structural transition between developed and developing countries. Since the greatest proportion of population ageing began in wealthy regions of the world such as Europe and North America, the demographic shift from a younger to an older structure occurs earlier in developed than developing countries (Beard & Bloom, 2015). The proportion of the population aged 80 years and above (the ‘oldest old’) is higher in developed countries than in developing countries (Uddid, Islam, & Kabir, 2013). One reason for this is the phenomenon of population shrinking that is currently experienced in developed countries. According to recently released UN projections, by the end of this century about two-thirds of the world’s countries will have shrinking populations, comprising almost 70 per cent of the more developed countries and about 65 per cent of the world’s less developed countries. In Europe, for example, the proportion of individuals aged 60 years or over is projected to reach 34 per cent by 2050, with a further slight climb to 35 per cent by 2100 (United Nations, 2015 ).

This trend is also supported by a report by the Statistical Office of the European Communities (2016), which states that in 2015, almost 27 million people aged 80 or over were living in the European Union (EU), which translates as one in every 20 persons living in the EU being aged 80 or over. In its report 2017, it was mentioned that the ‘oldest old’ segment of the population is growing at a faster rate than any other

age segment of the EU's population (Statistical Office of the European Communities., 2017b). This segment is projected to more than double in size between 2016 and 2080, from 5.4% of the population to 12.7% (Statistical Office of the European Communities., 2017a). In Europe, Sweden has the oldest population in terms of the percentage of persons aged 80 years and above, followed by Italy. At present, life expectancy at birth in Turkey is 69 years and is predicted to reach 78.5 years between 2045 and 2050. The current percentage of older adults in Turkey's population is 8.9%, which is predicted to approach 25% in 2050 (Güven, Şener, & Gürsoy, 2011).

It is in the world's low-income and middle-income countries, however that the greatest changes are currently being seen, owing to a sudden increase in the phenomenon of population ageing in these countries during recent years (Beard & Bloom, 2015). The United Nations has also projected that the number of persons aged 60 and above is expected to more than double by 2050 and more than triple by 2100; sixty-six per cent of the increase between 2015 and 2050 will occur in Asia (United Nations, 2013, 2015 2017). This means that, "the pace of population ageing in many developing countries today is substantially faster than occurred in developed countries in the past" (United Nations, 2015, p. 3). In addition, the World Health Organization (WHO) estimates that there will be more than 1000 million 'young old' (people aged 60 to 69 years) in the world by 2020, with more than 700 million of these living in developing countries (World Health Organization, 2011). According to the Economic and Social Commission for Asia and the Pacific (ESCAP, 2016), the number of 'young old' in Asia as a whole will more than double, from 322 million in 2000 to about 705 million in 2025. This projection is congruent with the successive reduction in mortality rate over the last fifty years in developing countries, thereby raising the average life expectancy at birth from around 41 years in early 1950 to almost 62 years in 1990. By 2020, life expectancy in developing countries is projected to reach 70 years (ESCAP, 2016).



**Figure 1-1: Distribution of the world’s population by age and sex, 2017**

Source: United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision. New York: United Nations.

Figure 1 presents the age of the world’s population within the context of its current age and sex distribution. At the global level, the numbers of men and women are shown to be roughly equal, and the proportion of older persons has increased while the proportion of younger persons has decreased. This phenomenon is expected to continue; according to the United Nation’s 2017 projections, by 2050 the number of persons aged 60 years or above will be equal to the number of children under 15 years.

### 1.3.2 Malaysian ageing population

The WHO has highlighted that there are currently more than 20 developing countries, including Malaysia, which have a growing life expectancy. Although Malaysia’s counterparts like Japan, India and China have larger older populations, the size of the older population in Malaysia has also increased steadily since the early 1990s (Karim, 1997). In the case of Malaysia, the history of its demographic structure shows the transition of age structure and indicates the country’s move towards an ageing population. It can be seen that there are three broad stages to this structural age transition. In stage 1, the predominant feature is the young-age-dependency ratio. This is followed in stage 2 by an increasing share of the working-age population. The final

stage is characterised by an increasing proportion of people in old age (Omran, 2005). Malaysia is experiencing a gradual decline in its young-age-dependency ratio. The number of persons below the age of 15 years relative to the number of people in the working-age population (15–64 years old) has fallen from 88.9 percent of the population in 1970 to 71.0 percent in 1980, and it has continued to fall, reaching 69.6 per cent in 2017 and a slight increase to 69.7 percent in 2018 (DOSM, 2016, 2017a; Navaneetham, 2002, 2018). In contrast, there is a continued increase projected for the dependency ratio of persons aged 65 and over to the number of members of the working-age population (15–64). This has been a 40 percent increase, from 9.3 per cent in 2018 to 21.7 per cent in 2040. Consequently, the percentage of old-age persons is projected to increase significantly from 6.5% in 2018 to 14.5% in 2040 (DOSM, 2015, 2018).

Another indication of the increase in the size of the old-age population in Malaysia can be seen in the rise in the median age of the population as the relative size of the younger population decreases (Tey et al., 2016; Zainab, 2014). The median age of the population in Malaysia rose from 19.6 years in 1980 to 21.9 years in 1991 and is projected to rise from 28.6 years in 2018 to 38.3 years in 2040. Furthermore, the total fertility rate has shown a remarkable decline, from 3.7 children born to women aged between 15 and 49 in 1992, to 2.1 in 2014, 2.0 in 2017 and 1.9 in 2018 (DOSM, 2015, 2017c, 2018). Therefore, the size of the Malaysian population is now increasing at a slower rate, with the rate of annual population growth projected to fall from 1.1 per cent in 2018 to 0.8 per cent in 2040. At present, the life expectancy of the Malaysian population at birth for all ethnic groups exceeds the projection from the WHO, and this has continued to increase over the past decades, reaching 75.15 years in 2018 compared to 72.2 years in 2000 (DOSM, 2017c).

In many of the developed nations in Asia, an ageing population has become a common phenomenon due to increasing longevity and declining fertility. With improved survival rates at all ages, this trend is likely to continue. According to the Department of Statistics (2018), Malaysia is expected to experience population ageing in 2030. At this time, the percentage of the population aged 60 years and over is projected to exceed 15 per cent. Although, the number of people aged 60 and over in Malaysia

remains small in comparison to some of the other Asian countries the above-mentioned indicators point to the country's population moving towards an ageing scenario.

## **1.4 Key Aim of the Investigation**

To summarise, the development of an ageing population in Malaysia will result in the need to adopt a holistic approach to ageing and policies capable of enabling it to become a nation with an old population who live positively during their later life. The aims of this study, therefore are to broaden our understanding regarding the expectations for old age as seen through the lens of middle-aged adults, to learn about their needs and priorities in this context and to identify the continued efforts required to provide a sustainable environment for the future for the old-age population.

The key aim of this research is thus to explore the conceptualisation of successful ageing among middle-aged Malaysian adults. The specific research objectives are stated below:

1. To identify the concept of the ageing self, according to middle-aged Malaysian adults;
2. To explore the normative beliefs, societal norms and reported external and internal barriers to achieving SA.

Following the Phase 1 data analysis, uncertainty and its management emerged as important aspects concerned with ageing successfully. The third aim of this study, as noted below, was formulated and explored through theoretical sampling with Phase 2 data collection (see Chapter 3, Sections 3.4.2):

3. To understand the experiences, priorities and support needed to cope with the uncertainty that impacts the ageing process amongst middle-aged adults.

## **1.5 Research questions**

1. When do middle-aged adults perceive the beginning of old age?
2. How do middle-aged adults conceptualise SA?
3. How are internal factors (e.g. Psychological aspects) and external factors (e.g. Social, cultural, lifestyle, environmental aspects) associated with SA?
4. How do middle-aged adults cope with uncertainty with a view to increasing their well-being in later life?

The first two research objectives and questions 1-3 are based on a general sociological perspective of SA. Research objective 3 and question 4 were added following the second interview sessions and are related to theoretical sampling aimed at gathering more information on the emerging themes.

## **1.6 The significance of this study**

The significance of this study is highlighted for several reasons below:

- The phenomenon of the increasing number of ‘young old’ (people aged 60 to 69 years) in Malaysia over the course of the coming years requires the building of knowledge related to the ageing experience of middle-aged individuals and the challenges they face in terms of their ability to age successfully. This information is critical to ensuring that effective strategies can be put in place.
- There is increasing evidence that the behaviour adopted during midlife is important in laying the foundations for one’s later life. To the best of the researcher’s knowledge, lay people’s perspectives in this area are limited, particularly with regard to people of Malaysian background.
- The national care of the older people in Malaysia is focused on a social protection system for working people through the Employees Provident Fund (EPF), 1951, the Social Security Organisation (SOCSO) formulated in 1969 and a pension system for public employees. Health care for the older people has been established to address illness care associated with ageing, in addition to public health and family interventions. However, there is the need to explore

a holistic and interdisciplinary approach to increasing well-being in later life within this community. The present study aims to provide a broader interpretation of SA, which may yield useful policy implications.

- “The emphasis on usual age may be linked to a tendency to encourage an over-readiness to treat age as if it itself were a sufficient explanatory variable. In fact, the emphasis on heterogeneity within age groups compels a search for other explanations as well” (Rowe & Kahn, 1987, p. 141). Moreover, research on the older adults should concentrate on the building of an understanding of age transitions to later life, especially on those that pose challenges to well-being.

Most concepts of SA tend to be employed uncritically and tend to reflect the academic discipline of the investigator’s point of view (Bowling & Dieppe, 2005). Given the enormous body of ongoing research, the existing model of SA might not be ideal for the Malaysian community without some form of critical appraisal and evidence of its relevance for older adults Malaysians themselves.

### **1.6.1 The scope of this study**

This study is set to embark on an exploration of the ageing process as it is experienced among middle-aged adults, both those with chronic illnesses and healthy individuals. This study is interpretative and is distinctive for its involvement of Malaysian adults. Its interest lies in understanding the range of issues and priorities that may affect people in day-to-day life and how these are sensed and handled in relation to ageing successfully. The present study attempts to provide a comprehensive understanding of the studied phenomenon, but it cannot be considered to provide a full representation of the general population.

It should also be noted that the study findings cover only adults in a particular setting, disruptive events in middle age and types of illness. Furthermore, I have undertaken this study in fulfilment of a PhD studentship award granted by the Ministry of Health, Malaysia. Therefore, it is subject to the stringent resources and limitations in the arrangement due to the distance between the current location of the researcher and the

study participants. However, all possible efforts have been exercised to ensure fulfilment of the methodological quality and rigour of the study.

Overall, the study aims to fill the knowledge gap in the existing model of SA and to pursue learning in the field of social gerontology. However, the data collection undertaken in this study has not been specifically formulated with the aim of making changes to those policies already in place for the community concerned. Therefore, the scope of this study is to examine the policies and strategies that need to be addressed when considering the limitations and strengths of the study that are mentioned further in Chapter 7.

## **1.7 Main terms and semantics used in this study**

There is no unified terminology for SA in terms of outlining a definitive set of components for a successful later life. Most notably, there are many terms that can be used to refer to an equal and similar understanding of SA, including ‘healthy ageing’, ‘robust ageing’, ‘optimistic ageing’, ‘good ageing’ and so forth, and these are discussed further in Chapter 2, Section 2.2.5. In terms of communication with the study’s participants, the local term ‘*berusia dengan sempurna*’ is used, which has a direct English translation of ‘perfect ageing’.

The terms ‘participants’, ‘respondent’ or ‘population in this study’ are used to refer to the individuals who took part in the study. In order to protect their anonymity, the researcher has used pseudonyms to refer to the individual participants. The term ‘midlife’ and ‘middle age’ are used interchangeably in the expectation that both terms convey the meaning of referring to the central period of life prior to the onset of old age. The personal stories told by the participants to explain their perspectives of SA have been kept anonymous, with no details given related to the setting and identification of the individuals involved. The frequently used terms and abbreviations in this study are also listed and explained in the abbreviation and footnotes sections.

## 1.8 Outline of the thesis

This thesis is organised into seven chapters, as follows:

**The first chapter** sets the scene of the studied phenomena. It discusses the current development of ageing populations from both the global and Malaysia perspectives. The chapter then proceeds to introduce the context of SA and the rationale for studying this phenomenon. The current increase in the size of the ageing population in Malaysia points to the importance of this study especially given that midlife is a pivotal period of the life course in terms of its influence on old age.

**The second chapter** contains a detailed review of the literature related to the current development of the ageing phenomenon within the field of SA. This chapter also discusses the element of uncertainty and the coping strategies seen in different fields, in addition to their impact on SA. There is continuous development of the theoretical understanding of the SA model in terms of defining the concept and its constructs in varied contexts. Despite this continual development, however, a total of only five qualitative studies were identified in the systematic literature review on the paradigm of SA that were conducted with middle-aged adults and aimed to understand their lay perspective for ageing successfully. The justification for undertaking the current research is thus presented in this chapter by exploring the knowledge gap noticed in the mentioned field.

**The third chapter** discusses the methodological aspects underpinning this study, including the ontology and epistemology, and the methods employed to arrive at its findings. There is an in-depth exploration of the relevance of Constructivist Grounded Theory (CGT) to this research. The ethical considerations of this study as shown through the reflections of the researcher highlight the importance of being prepared for addressing participants' emotional distress during interviews along with efforts to maintain the rigour of the study. In this chapter, the researcher describes the field experience during the data collection and data analysis phases, along with the relevance of maintaining memos and reflective journals.

**The fourth chapter** elaborates on the exploration of the findings of this study. It contains the study's findings in relation to the changes in midlife that influence the

perspectives of ageing and SA. This study suggests that the perspective of SA among the study population is multidimensional and is indicative of a life course approach. The occurrence of disease is seen as a consequence of ageing, as being associated with other issues and is tackled beyond a personal level, in which the research participants involve their family members and other people in the community. It was noted that the participants took into account the issues experienced by other people (particularly by significant others and those close to them) as well as their own disruptive events, and these had the potential to emerge as uncertain events for the participants. Ambiguities surrounding midlife and those that are considered to challenge old age are detailed in this chapter. These sources of ambiguities that are derived from disruptive events are mainly from biomedical factors, personal factors and unfulfilled social norms.

**The fifth chapter** contains a further exploration of the findings of this study. It identifies the dimensions of the uncertainty which itself was found to vary according to the nature of the issue, the knowledge of the experiencer, their own judgement of the anticipated risks and the novelty of the issues that change as time progresses. It also explores further on how the people within this community react in the face of adversity and the ways in which they develop protective mechanisms. The strategies adopted to cope with uncertainties are unique to the population of this study, and are underpinned by being resilient, building interdependent relationships with family and social institutions, creating a balance and modifying lifestyles and behaviours. The conceptual model for uncertainty and successful ageing is presented in this chapter.

**The sixth chapter** discusses the findings that are presented in Chapters 4 and 5 against other studies related to these findings. The chapter is then further developed around the factors contributing to the advancement of 'self' and how people in this study are guided towards coping strategies. Unlike the biomedical model of SA discussed in Chapter 2, Section 2.2.4, the perspectives of SA among the research participants denote health and physical ability as a non-direct component that influences SA. Most of the participants in this study turned to religion and family members to support them during adverse situations, which is a value that has been highly noted in studies conducted among people of Eastern faiths.

**The seventh chapter** links the findings of the previous chapter to the aims and

research questions stated in Chapter 1. It also includes the limitations faced when conducting this study in addition to those aspects that have impacted on the overall findings. The chapter ends with recommendations for future research within a similar domain. Future studies are recommended to explore the relationship between uncertainty and the concept of SA, to minimise the knowledge gap concerning the disparity noted between the intention to age successfully and the actual behaviours enacted with regard to its achievement. The current study acknowledges important contributions to the existing theoretical perspective underpinning the concept of ageing successfully.

## **Chapter 2 : Literature Review**

This chapter contains a review of the literature available in the field of social gerontology and, more specifically of the literature that focuses on ageing experiences and successful ageing. Firstly, the chapter begins with an explanation of the database search strategy used by the researcher to extract relevant works from the literature. Secondly, it critically describes the existing knowledge and unfolds the social perspectives of successful ageing models. Later, it describes the ‘disruptive events’ and midlife uncertainty found in the existing literature. It then contains a further section describing the current development of the ageing population, relevant policies and the related services that are available and adapted for the ageing population in Malaysia. Finally, it discusses the gap in knowledge that has led to the present drawback and its contribution to existing theoretical conceptualisation and policies.

### **2.1 Database search strategy**

Systematic search activities were conducted on selected journals, with computer searches in English related to successful ageing (SA) in midlife. The database search of relevant journals remained ongoing right up to the completion of this thesis. The initial systematic search was carried out in 2015 and subsequently updated in July 2017 with a search for new papers published between the years 2016 and 2017. The focus of the search was also widened to include the development of SA models, issues associated with the theoretical conceptualisation of SA and uncertainty in midlife, and activities to cope with the achievement of SA in later life (see Figure 2-1).

As seen in Figure 2-1, the search strategy for this literature review involved the sorting of studies into four categories. The studies in the first category (A) discuss the perspective of ageing extracted from the review. In all of the searches performed, the issue of spelling variations between British and American English for ‘ageing’ or ‘aging’ was solved using the Boolean operator ‘OR’. Furthermore, the truncation ‘\*’ (or wildcard searching) was used in the search to accommodate the variations in spelling. Although this strategy could not be utilised with the set terms of controlled vocabulary, it proved to be a powerful aid in improving the sensitivity of free text searches. The studies in the second category (B) contain perspectives on SA, including

the common substitute terms used in the literature. As discussed in Section 2.2.5, the term SA is very often used interchangeably with other terms since there has been no ideal term or characteristics determined in relation to either definition for use in respect to the notion of well-being in later life. Some authors used terms such as ‘healthy’, ‘successful’ and ‘active’ or ‘positive’ in their studies to avoid bias in the responses provided by the study respondents (Bowling, 2008, 2009; Brundtland, 2002; Chong et al., 2006a; Peter Martin et al., 2015; Pruchno, Wilson-Genderson, & Cartwright, 2010). Consequently, in this review of the literature, the term successful ageing included a range of alternative terms such as: ‘productive ageing’, ‘resourceful ageing’, ‘independent ageing’, ‘healthy ageing’, ‘active ageing’, ‘ageing well’, ‘positive ageing’, ‘robust ageing’ and ‘meaningful ageing’, to ensure that no SA paper would be missed. The searches performed included a combination of the aforementioned terms, although for the purposes of this study the researcher uses successful ageing (SA) throughout the thesis as it is one of the most commonly used and accessible terms in the literature (Hsu, 2007; Iwamasa & Iwasaki, 2011). The discussion of this search is presented in Section 2.4. The third category (C) comprises studies that address the disruptive events, normative beliefs and internal and external barriers that underpin individuals’ behaviour for SA. Key words such as risk, disruptive events, security, issues, problems, change, challenges, disability, dependence, social norms and status were used as search terms (see Figure 2-1). Finally, category 4 (D), includes those studies that underline uncertainty and the coping strategies used in midlife.

The following electronic databases were used for this review: MEDLINE, PsycINFO, Science Direct (Elsevier Journals), Social Sciences Citation, Bibliography of Asian Studies (BAS), Cambridge University Press journal and ProQuest Nursing Journals. Other websites used in the review were ‘Web of Science’, ‘CINAHL’ and ‘COS (conference papers Index through proquest)’, with the latter focusing on conference papers and conference proceedings. In addition to this strategy, I also set up email alerts from the main databases in order to obtain the most recent journal publications (see Appendix 29).

Relevant documents about the ageing population in Malaysia, special programmes for the older people and policies (e.g. Departmental meeting minutes, reports and presentations) were included to explain the significant information that contributes to the knowledge of the existing development of ageing care in Malaysia. These documents were obtained from the related ministries in Malaysia, mainly from the Ministry of Women, Family and Community Development (MWFCD) that is the secretariat for the National Advisory and Consultative Council for Older Persons, the Ministry of Health, Ministry of Housing and the Department of Social Welfare.

As a means to ensure the validity of the literature obtained, the articles were checked in order to ascertain if they had been peer-reviewed, were supported by documented references and that they clearly stated their methodology and objectives, limitations and possible bias in the study. I used the web-based bibliography manager Endnote to facilitate referencing in this study. This also assisted in the performing of advanced searches by author, subject and keywords and in the exporting of references into documents in a number of standard formats. As with all automatically generated citations, the in-text citations and reference lists were double-checked for accuracy (Mckinney, 2013).

Figure 2-1 shows the review strategy with the keywords and terms used in the database search for this thesis.

A

**Search terms for ageing**  
Ageing and perception  
**Or**  
Aging and perception

B

**Search terms for successful ageing**  
(successful or happy or harmonio?s or robust or productive or resourceful or independent or healthy or active or positive or resilience or competent) adj2 ag?ing.ti,ab.

C

**Search terms for disruptive events**  
risk or disruptive event\* security or issues or problem or change or challenge  
**Or**  
*disability or* independ\* or depend\* or well?being or soci? norm? or status  
**And**  
(mid\*dle age or midlife or working group) adj2 ag?ing).ti,ab.

D

**Search terms for uncertainty**  
uncertainty or ambi\* or ambivalence or fear or identity or resilien\* or coping  
**And**  
(mid\*dle age or midlife or working group) adj2 ag?ing).ti,ab.

Figure 2-1: Keywords and terms used in the database search

## 2.2 Key terms in the present study

### 2.2.1 Middle age

Middle age is the period between adulthood and the onset of old age. Unlike adolescents, people in middle age do not pass through any predictable chronological events, such as puberty, that mark the transition from young adulthood to middle age (Featherstone & Wernick, 1995). Therefore, identifying the period of middle age is much like defining a time in history; it is difficult to obtain a consensus definition as to when middle age begins or ends (Farrell, 1981). Moreover, the definition of social age is inconsistent from one institution to another (Neugarten, 1968).

In some societies, ageing is defined by custom and religious understanding. For example, in India, middle age (*prorha*) is defined as referring to someone who is “older; between thirty and fifty; whose intelligence is fully developed; experienced” (Shweder, 1998, p. 76). Similarly, Fiske (1979) mentioned that middle age is the life period during which most people have become mature in the way they think, feel and act; they have intense religious and cultural practice, and a person between the ages of 40 and 50 has good mental health and seems to be satisfied in family life. Therefore, middle-aged males are viewed as mature members of some communities when they take up the responsibility of parents and family, adapting and coping with social expectations to the best of their abilities (Farrell, 1981).

In addition, significant differences exist between men and women as they age (Shweder, 1998). Middle-aged women tend to define their age status in relation to the timing of events within the family cycle. Neugarten (1968) for instance, in a study conducted among 100 middle-aged adults, mentioned that for married women this period of life is closely linked with having grown-up children, with even unmarried women associating middle age with the family that they might have. With women’s increased sense of freedom – whether they are married or single – middle age marks the beginning of a period in which their latent talents and capacities can be put to use in a new direction. In Neugarten’s (1968) study, men, on the other hand, appeared to cope with changes to their environment and health in an abstract and cognitive context, often being influenced through a work setting, in comparison to women. However, for

both genders, the middle years of life represent a critical turning point in the formulation of self, time and death (Neugarten, 1968).

Changes in economic trends, career paths and demographic patterns in modern society have influenced the traditional view of parenting roles and the idea of midlife as being characterised by specific roles or a period of parenthood, or as being highlighted by marital status, as illustrated by Willis and Martin (2010). Middle age is also perceived as a period when ageing-related problems begin, for example chronic illness and mental health issues (Deeg & Huisman, 2010). Thus, it might be difficult to define the time when middle age begins or ends according to individual variations in relation to gender, social class and the effects of the type and timing of role transitions (Farrell, 1981). Especially, middle age in comparison with other phases of life, such as the teenage years or younger age is highly influenced by socio-cultural and environmental factors. Some theorists studying life course development have suggested that the period of middle age is multidimensional, more likely to be influenced by socio-cultural impacts as opposed to biological disruption based on growth of the kind seen in periods of biological change such as puberty (Baltes, 1987; Staudinger & Bluck, 2001). As a result, the subjective age of middle age is likely to change according to variations in demography, health status, economic structure and modifications to social and health policies. In two cohort studies conducted among middle-aged adults, the age range of the respondents defined as middle-aged spanned two decades; 40–60 years (Allemand, Gomez, & Jackson, 2010), and 55–64 years, with an interval of 10 years (Deeg & Huisman, 2010). In the Malaysian national pension scheme, the maturity age for the pension benefit is 60 years. Given the accumulating evidence, the period of middle age in this study is thus considered to be between 40 and 59 years.

### **2.2.2 Old age**

The United Nations denotes old age as 60 years and above in its report ‘World Population Prospects: The 2017 Revision’ (United Nations, 2017). Gerontologists, in contrast, recognise the diversity of old age by defining sub-groups: young old (60 to 69), middle old (70 to 79) and very old (80 and above) (World Health Organization, 2002b). A study by Selvaratnam et al. (2007) conducted among the Malaysian community used the definition given by the World Health Organization to identify and

classify the older population. According to ASEAN and the World Assembly of Ageing held in Vienna in 1982, older people are referred to as those over 60 years of age (Derahman, 2017b).

Ageing is the process of growing old. It involves an irreversible physiological process that affects everyone, including those with physical and cognitive limitations, threatens emotional well-being and represents the loss of both social and economic status (Hartman-Stein & Potkanowicz, 2003). Although age and ageing are associated with biological phenomena, their meanings are socially and culturally defined (Balard, 2011). In other words, the meaning of both being old and older age are constantly created, renewed and diversified. It is therefore challenging to identify a universal term for old age due to the fact that the definition shifts according to the context. In developing countries, for example, old age is often defined by new responsibilities and the loss of previous functions, or the ability to contribute actively to the community instead of being defined by the numbers used to denote age (World Health Organization, 2002b). Furthermore, old age is conceived differently based on cultural differences (e.g. Family position and social responsibilities) rather than being related to biological decline such as back pain or the menopause (Shweder, 1998). The perception of old age also seems to vary geographically. In urban settings, the 'old' are defined as those who have retired from a full-time job, and the term is associated with reduced activity levels and increasing positivity (Fiske, 1979; Shweder, 1998). Retirement is also related to the definition of old age because it represents an obvious transition at the social level. This is because a retiree who receives a pension (or Employment Providence Fund) is deemed to be a passive contributor to society (Kok & Yap, 2014). In sum, from a lay perspective, the identification of a person as 'old' is often carried out through their social roles and not by their biological age.

In Malaysia, old age officially begins at 60, with older people being referred to as '*Warga Emas*' (The Golden People) in the Malaysian national policy for older people care. The definition of old age as beginning at 60 years was also endorsed at a meeting between the MWFC and relevant ministries- the Ministry of Health Malaysia (MOH), Ministry of Economic Affairs, Department of Statistics Malaysia (DOSM), Social Welfare Department, National Population and Family Development Board

Malaysia (LPPKN) and the Malaysian Research Institute on Ageing in University Putra Malaysia - held on 14<sup>th</sup> August 2018 (see Appendix 31) The '*Warga Emas*' policy entitles older people at the age of 60 years to receive various short-term and long-term benefits.

### **2.2.3 Ageing**

Ageing is traditionally constructed as a problem from the viewpoint of biological change, being associated with old age and illness, disability, disengagement and decline, and, ultimately, death (Pike, 2011; Togunu-Bickersteth, 1988). It was in the mid-1960s that these typical images of ageing shifted to more positive images of an ageing culture. The advancement in consumer culture initiated a positive image of ageing, whereby seniors who were previously depicted as sexless, senile, crotchety, frail and unhappy came to be relabelled with positive phrases such as ‘life begins at 50’ and ‘the older they get the better they look’. These messages were not aimed at retirement promotion, but they were used to sell products that complement being older adults (Featherstone & Wernick, 1995).

Nevertheless, Eugene Loos (2014), studying the notion of generations and literature related to the visual representation of ageing, highlighted the image of ageing as an interpretative process. Such interpretative meanings of ageing are attributed differently across cultures; in Japan, for example, wrinkles and frailty are regarded as being ‘cute’ and such things are a source of affection among young people (Featherstone & Wernick, 1995). Japanese culture embraces and celebrates old age throughout older adulthood, with each decade of ageing carrying a special significance: Kanreki (60th birthday), Koki (70th), Kiju (77th), Sanju (80th), Beiju (88th) Sotsuju (90th) and Hakuju (99th) (Iwamasa & Iwasaki, 2011).

Studies in the field of ageing mostly have focused on individual differences in the perceptions of ageing, mostly from a Western background, but there is growing evidence that views of ageing may also differ across cultures (e.g. (Arnhoff, Leon, & Lorge, 1964; Giles et al., 2000) here is also evidence presented that Western and Eastern populations hold different viewpoints on concepts such as the ‘individual’ and ‘self’. Westerners typically see a person as ‘bounded’ or autonomous, in contrast to non-Westerners, who view individuals as being relatively unbounded and with less emphasis on individuality (Shweder & levine, 1984). Broad East-West comparisons in studies have indicated a small but significant effect, whereby participants from Asian cultures hold more positive collective views of ageing than people from Western cultures (Löckenhoff et al., 2009).

## 2.2.4 Successful ageing

This section traces the understanding of the theoretical conceptualisation of SA. The idea of SA can be traced back to as early as 106–43 BC and the Roman philosopher Cicero, who produced the very first claim about the positive changes of ageing in his essay ‘De Senectute’ (44 BC/1979), which turned the negativity of ageing into a positive prospect of vitality and activity. Cicero gave a new perspective to old age, seeing it not as a phase of decline and loss, but rather as one that may bring many opportunities for positive change and productive functioning if approached properly (Baltes, 1990; Bowling, 2008; R. A. Pruchno et al., 2010).

However, three prominent researchers in the gerontology/psychology field—Havighurst (1961), Rowe and Kahn (1982) and Baltes (1990) – provided the early analytical concept of successful ageing and had a significant influence on future research concerning SA. However, their conceptualisations did not present a standard measurement that could be used to define the constructs of SA. Although Rowe and Kahn’s model of SA revolutionised the study of ageing, it has also drawn some critique. This has included, for example, a lack of agreement about what successful ageing means in different contexts; a lack of clarity in the objectives and sample characteristics of their study (Cosco, 2013; Pruchno et al., 2010); a restrictive focus on physical and cognitive health (Crowther et al., 2002); the problematic assumption that all three traits suggested by Rowe and Kahn’s model (see Section 2.2.4.2) are equally weighted across all age groups (Hodge et al., 2013); and the exclusion of psychological traits such as spirituality and well-being (Crowther et al., 2002). Nevertheless, SA has been influentially used as directing evidence in gerontology research and as a challenge for designing social policy from the mid-1980s and thereafter. Some of its prominent contributors are Rowe & Kahn (1997), Ryff (1982), Baltes & Lang (1990), Butt & Beiser (1987), Palmore (1979), Cumming and Henry (1961) and Strawbridge (1996) among others. Section 2.3 discusses the analysis of the conceptualisation of SA and its development from the breadth of literature reviews. The seminal works by Havighurst, Baltes, Rowe and Kahn, which have contributed to the development of SA as a concept, are discussed in the following sections.

#### **2.2.4.1 Theoretical concept of SA by Robert J. Havighurst (1961)**

In the 1960s, Havighurst proposed that ‘life satisfaction’ – understood as the skill to relate to the main goal of life in old age, emphasising developmental continuity and inner satisfaction – can be used for measuring constructs of SA (Havighurst, 1961). Havighurst associates his proposed activity theory with SA, asserting that the individuals who succeed in ageing are those people who engage and actively get involved in their desired activities. Activity theory is a concept of life course process; it states that, in order to maintain a positive sense of self, older individuals must find new roles to replace those lost in old age (Schroots, 1996). “Activity theory was linked to the later theory on transcendence through the importance of a sense of connectedness, generativity, altruism and purpose in life, each integral to transcendence” (Mccarthy & Bockweg, 2013, p. 85). Transcendence, according to Mccarthy, is a shift in perspective “from a rational, materialistic view to a wider worldview within interpersonal, intrapersonal, transpersonal, and temporal dimensions” (p. 89).

#### **2.2.4.2 Theoretical concept of SA by John W. Rowe and Robert L. Kahn (1987)**

The concept of SA introduced by Rowe and Kahn in 1987 (Rowe & Kahn, 1987, 1997) in MacArthur’s study is the best-known and most significant research. It has stimulated and provided the theoretical underpinnings for many of the operational definitions of SA (Depp & Jeste, 2006; Dillaway & Byrnes, 2009). The concepts of SA formulated by Rowe and Kahn have gone on to formulate the multidimensional character of the ageing process and stimulated further studies, particularly in the medical field (Lowry, Vallejo, & Studenski, 2012). The aim of MacArthur’s study was to recognise the risk factors that were associated with SA, so that potential prevention activities to initiate SA could be planned. Rowe and Kahn argued that within the category of ‘normal ageing’, a distinction can be made between ‘usual ageing’ and ‘successful ageing’ (SA) and that SA can be differentiated from ‘usual ageing’ by the impact of extrinsic factors (Kusumastuti et al., 2016). In the model proposed by Rowe and Kahn, it is stated that many effects of ageing are associated with illness and it was proposed that individuals who fall into the category of ‘usual ageing’ will display illness and

functionally oriented decrement (Pruchno et al., 2010). In their paper, Rowe and Kahn (1987) proposed that people might be viewed as having aged successfully with regard to the particular variable under study. “People who demonstrate little or no loss of the constellation of physiologic functions would especially be regarded as being more broadly ‘successful’ in physiological terms” (Rowe & Kahn, 1987, p. 237).

This most popular concept of SA by Rowe and Kahn encompasses three dimensions:

1. Absence of disease and disease-related disability,
2. High cognitive and physical functional capacity (Activities of Daily Living (ADL), and
3. Active engagement with life.

#### **2.2.4.3 Theoretical concept of SA by Paul B. Baltes (1990)**

Baltes (1990) describes the concepts of ‘diversity’ and ‘plasticity’ to prescribe the optimal psychological processes of SA through his model of ‘Selection-Optimization-Compensation’ (SOC) (Hsu, 2007; Timonen, 2017). The SOC model involves three domains that ground SA: 1) Selection – the selection process occurs when an individual’s expectation is adjusted by redirecting efforts and resources to optimise subjective experiences; 2) Optimisation – an optimisation process occurs when people engage in behaviours that strengthen their resources for achieving their goals; and 3) Compensation – a compensation process explains how adaptive behaviour operates when specific behavioural capabilities are lost or decline below the standard required for adequate functioning. These processes, as a whole, lead to the establishment of new resources for maintaining expected outcomes (Baltes, 1990; Timonen, 2017). People who master these developmental tasks through sensorimotor, cognitive, personality and social resources are able, according to Baltes, to integrate successful ageing in later life (Baltes & Carstensen, 1996; Baltes & Lang, 1997; Baltes, 1990). These components propose the integration of multiple objective and subjective criteria to help to materialise successful ageing when faced with advancing age (Baltes, 1990).

### **2.2.5 Other terms defining successful ageing**

There has been a vastly increased focus on the constructs of SA in the field of gerontology studies since the introduction of Rowe and Kahn's model of SA in the field of gerontology studies. Various definitions have been coined and the conceptualisation of SA has seen continuous development as mentioned in the this section and 2.2.5.2 (Bowling, 2006; Bowling & Dieppe, 2005; Mccarthy, Ling, & Carini, 2013; Phelan & Larson, 2002; Timonen, 2017). It is not only SA that is subject to variations in definition, the adjectives used to describe its constructs are also used differently and interchangeably in studies (Pruchno & Carr, 2017).

Some of the alternative terms found in studies include healthy ageing, ageing well, productive ageing, positive ageing, robust ageing, active ageing, and many others (Bryant, Corbett, & Kutner, 2001; Butler, Fujii, & Sasaki, 2010; Chong et al., 2006a; Hsu, 2007; Sixsmith et al., 2014; Strawbridge, Wallhagen, & Cohen, 2002). On the other hand, Fernandez-Ballesteros et al.(2010; 2008) suggested that the terms active, healthy, successful, optimal or productive ageing are strongly interrelated and are multidimensional concepts, referring to a positive way of ageing however a commonly accepted definition is still missing.

For all of these terms, however, the term successful ageing has remained the umbrella term (Kahn 2003), with the alternative terms serving to expand and improve upon the constructs underlined in SA. Thus, the concept of SA is still the dominant conceptual framework which is most frequently referred to in relation to ageing and well-being in later life (Liang and Luo, 2012). The literature search for identifying concept of SA was undertaken in various communities and indicated at least 11 alternative terms used for SA by scholars: Ageing well, healthy ageing, active ageing, balanced ageing, positive ageing, happy ageing, harmonious ageing, robust ageing, productive ageing, resourceful ageing and independent ageing. However, the majority of these terms were not recorded as being definitions distinct from the term SA, but rather they seemed to be interrelated with it in some respects. In this section, some of the active terms used to describe SA or which are interrelated with the term in the literature have been defined.

### **2.2.5.1 SA from social perspective**

Other terms that describe SA also carry meanings beyond the biological and medical aspects, and these include maintaining well-being and quality of life throughout the ageing process (Waugh & Mackenzie, 2011). The concept ‘balance ageing’, for example, place emphasis on achieving a balance between needs and functions as being part of balanced ageing. This concept of ageing highlights the importance of psychological support, such as religious aid in treating imbalances in life such as resignation, to address issues associated with decline in physiological function (Butler et al., 2010).

Some researchers used the term ‘harmonious ageing’, thus giving importance to the balance of body and mind and also highlighting the nature of a human being as existing interdependently alongside other people and their surroundings (Liang & Luo, 2012).

The term ‘positive ageing’ was used to describe well-being in older age as engagement in healthy activities, social participation and financial security (Chong et al., 2006a). There are many scholars who also denote positive ageing as being related to other terms such as healthy ageing, active ageing, productive ageing and SA (Cheung & Lau, 2016; E. Kahana, Kelley-Moore, & Kahana, 2012; Phelan et al., 2004b; Strawbridge et al., 2002; Vaillant & Mukamal, 2001).

Productive ageing involves an emphasis on an individual’s capacity to continue working, retain their human capacity to be productive, have political participation and contribute to their well-being and build a sustainable community (Davis et al., 2012; Peng & Fei, 2013; Yang, 2010). A review of productive ageing studies conducted by Arbesman and Lieberman (2012) used this term to identify articles that studied the effectiveness of occupational therapy with older adults. This review of articles linked productive ageing to physical mobility and identified the types of interventions that were most beneficial to people with Alzheimer’s disease and related dementia, including engagement in ADL and leisure, and occupation-based intervention, activity and environmental adaptation.

### **2.2.5.2 SA from functional perspective**

The WHO has promoted healthy ageing as its concept for ageing-related work from 2015 to 2030, thus replacing its previous active ageing policy that was developed in 2002. The previous concept of active ageing was underlined as a process of capacity building and engaging in health-sustaining activities, security and quality of life as people age (World Health Organization, 2001, 2002a). The objective of active ageing policies is to move individuals to the highest level of function possible for their age (Oxley, 2009). Healthy ageing is a key aspect of active ageing which shifts the public health goal from a 'needs-based approach' to a 'rights-based' approach that affords everybody an equal chance and treatment (Chong et al., 2006a).

Sustaining an individual's functional ability in his/her later life was the main key aspect used by the WHO to define healthy ageing in its first world report on 'Ageing and Health' published in 2015. The report reviews ageing from a life course perspective with special emphasis on the second half of life. The functional ability of older adults was described as the interaction between older people and the environment they inhabit, where a good fit between them will build both the intrinsic capacity (composed of a person's physical and mental capacities) and the functional ability of an older person (WHO, 2015). Healthy ageing, thus requires strategies targeted at building intrinsic capacity across the life course (Beard et al. 2016).

However, when considering the population at large, functional ability and intrinsic capacity can change across the second half of the life course. It is therefore, proposed that the healthy ageing model conceptualises resilience through resistance, recovery and adaptation as the key ability to sustaining and building a level of functional ability in the face of adversity. As a whole, the aim of healthy ageing is to create the opportunity for individuals to perform things that matter to them even at times when their intrinsic capacity has fallen below its peak through providing a supportive environment. Hence, in the report, the WHO recommends activities such as understanding and evaluating the influence of events at varied stages in time to assist in recognising the intervention that brings the highly significant impact during an individual's life.

Healthy ageing, also mostly used in public health, according to the WHO (2001), is a life course investment in health promotion initiatives which include engagement in activity, health, independence and productivity in later life. Healthy ageing is also described as containing subjective experiences in life, such as actively participating with families, communities, having security, autonomy and cultural factors that enhance well-being in later life regardless of whether the individuals in question are healthy or sick (Bryant et al., 2001; Hsu, 2007; Manasatchakun et al., 2016; Walker, 2002). In a study of active and healthy ageing measures reported for the 28 countries of the European Union, four domains of measurement were used: “employment; participation in society; independent, healthy and secure living; and capacity and enabling an environment” for active ageing (Zaidi et al., 2017, p. 143). Some scholars regard active ageing and healthy ageing as overlapping with successful ageing (Bryant et al., 2001; Peel et al., 2005). Similar to the term active ageing, healthy ageing emphasises enabling older people to remain as a resource for their families, communities and economies (World Health Organization, Extracted on 16th January 2018).

## **2.3 Critical analyses of the theoretical conceptualisation of SA**

This section will examine the theoretical conceptualisation of SA and its critical analysis against the growing evidence of literature in this field.

### **2.3.1 Varying theoretical understandings**

Although the model put forward by Rowe and Kahn led to greater effort in defining a heterogeneous population who have prevented pathological deterioration, some researchers have recommended multidimensional models of SA to include different age groups, cultural backgrounds and demographic factors (Cheung & Lau, 2016; Grundy & Bowling, 1999; Nosraty et al., 2012). For example, two systematic reviews conducted by Depp and Jeste (2006) and Cosco et al. (2014) revealed 28 definitions and 105 operational definitions of SA, respectively. According to Virpi Timonen (2017), the enormous development in the conceptualisation of SA does not mean that the concept is insignificant or too vague to have exerted an influence on the study of ageing, but rather that it serves to illustrate the demand for a summative concept that

underpins all cases through a particular understanding of what constitutes ‘success’ in ageing. However, there are specific issues that prevent such a clear assessment of successful ageing being used as a basis for identifying the prevalence or incidence of successful agers from all cases (Peel et al., 2004; Peel et al., 2005). In Section 2.3, the development of successful ageing conceptualisations in a diversity of populations, genders and backgrounds that enrich the adaptability of the SA model and the challenges of having a common assessment are discussed in turn.

The biomedical theoretical concept of SA that places more emphasis on physical functioning and the absence of disease has seemed to be irrelevant with regard to the oldest-old adults (Cho, Martin, & Poon, 2011; Cho, Martin, & Poon, 2015; Iliffe & Bowling, 2011; McLaughlin et al., 2010; Von Faber et al., 2001). A relevant example of this inadequacy can be seen in the findings highlighted by Cho et al. (2011), which utilised the construct of SA proposed by Rowe and Kahn. The study’s findings showed that none of the research participants (as members of the American oldest-old population) achieved the criteria underlined for SA. A systematic review and meta-ethnography conducted of 26 qualitative peer-reviewed studies of lay perspectives among individuals between 50 and 80 years of age identified that SA was mentioned beyond physical health and that it was frequently associated with psychosocial (attitude)-related components (Theodore D. Cosco et al., 2013).

This suggests that, more than any limitation that may be caused to them by illness, positive psychological aspects enable the oldest old to achieve SA (Jeste et al., 2013). Some researchers have adjusted the definition of SA proposed by Rowe and Kahn, thus providing a new context for SA, including individuals who exhibited minimal rather than no illness and disability (Guralnik & Kaplan, 1989; Roos & Havens, 1991; Seeman, Rodin, & Albert, 1993). This therefore shows that the quest for goal attainment varies according to disparate standards and norms (Baltes & Carstensen, 1996).

### **2.3.2 Lay perspective versus clinical perspective**

In the breadth of literature on lay perspectives, the studies highlighted the importance of subjective criteria as something that had been omitted from the theoretical model of

SA developed by earlier scholars. It was noted in the research clustering successful ageing that many of the older respondents with chronic disease and functional limitations rated themselves as ageing successfully, even though they did not meet the operationalised definition of successful ageing (Carpentieri et al., 2017; Cosco et al., 2013; Emlet et al., 2017; Jang et al., 2004; Pruchno et al., 2010; Romo et al., 2013; Sixsmith et al., 2014; Strawbridge et al., 2002).

In a quantitative study using grounded-theory type analysis extracted from semi-structured interviews concerning factors that contribute to healthy ageing, Lucinda. Et al. (2001) found that participants mentioned health as a non-static component and as an ongoing interactive factor that balanced the model's components to achieve the goal of doing something meaningful. Therefore, Lucinda et al. (2001) reported that most of the SA studies construct the concept of 'health' from a positivist perspective that contrasts it with 'disease' rather than the interpretive-constructivist concept of 'wellness-absence of illness'. Furthermore, Pruchno et al.(2010) conducted telephone interviews with 5,688 adults between 50 and 74 years of age and suggested that the SA model cannot be measured by objective evaluation alone but rather that it should also incorporate subjective experience. Pruchno et al. (2010), whose works are highly referenced in studies on ageing, concluded that, although objective criteria are important components of SA, they do not tell the whole story.

There is clear evidence that in the earlier models of SA, it was usual to discuss SA from the perspective of researchers or clinicians, while the lay perspective was neglected (Cosco et al., 2014). Some studies highlighted this limitation concerning the explicit input of laypersons, such as Strawbridge et al. (2002) in a longitudinal study containing 867 participants; Montross et al. (2006), who conducted a survey among 205 community-dwelling adults; and Phelan et al. (2004a), who conducted two cross-sectional studies among two cohorts: second-generation Japanese Americans, and Whites aged 65 years and above. They found a discrepancy between the definition of successful ageing as operationalised by the researchers and successful ageing according to the perceptions of older people.

Another prominent study with lay people was conducted by Bowling (2006), who, in attempting to explore the perceptions of SA among British respondents aged over 50,

compared the analysis according to different age groups in order to highlight the differences in SA across age. Bowling explored the definition of SA through open-ended questions by asking the research participants, ‘What do you think are the things associated with SA?’ The participants agreed with the existing theoretical concept of SA, with aspects including health and physical functioning, but they also highlighted the importance of emotional well-being, being motivated, social support, roles in society, financial stability and living conditions. These differences between lay people and clinicians are important challenges that are reflected by the SA model. Bowling and Dieppe (2005) highlighted the importance of investigating lay perspectives in order that the theoretical models may include social significance and the values that people hold. This exploration of the literature involving lay perspectives becomes multidimensional because such perspectives successfully integrate the objective and subjective criteria for ageing (Bowling & Dieppe, 2005; Cosco et al., 2013; Depp & Jeste, 2006; Romo et al., 2013).

Overall, in the self-reported studies of SA, the older adults who did not meet the objective measurements for SA still rated themselves as ageing successfully (Cernin, Lysack, & Lichtenberg, 2011; Montross et al., 2006; Pruchno et al., 2010). The objective criteria highlighted as being measurements for SA in the earlier constructs of SA (such as physical functioning and health) were balanced with acceptance, adaptation to new situations, adjusting to a new body capacity, external support and emotional well-being (Havighurst, 1961; Knight & Ricciardelli, 2003; Laditka et al., 2009; Lewis, 2011; Tate, Lah, & Cuddy, 2003; Troutman, 2010; Von Faber et al., 2001). Tate and his colleagues (2003) conducted the Manitoba Follow-up Study on Canadian males recruited from the air force at the end of World War II and disclosed the participants’ responses in order to identify the definition of SA and their attitude towards ageing. In this study, the inclusion of subjective constructs such as family relationships, having a goal in life, having a good diet alongside objective components such as health and physiological and psychological aspects suggests a multidimensional model of SA.

### **2.3.3 Gap in knowledge of cultural practices and SA**

The concept of SA also varies according to cultural and societal norms, which has been omitted from in the biomedical theoretical conceptualisation. A study by Hsu (2007) exploring the perspectives of SA among the older people in Taiwan recommended that the priority of ‘health’ for ageing successfully might change according to its circumstance. The participants in the study were asked to respond to an open-ended questionnaire about what they considered to be the important components of an ideal and satisfactory life in old age and were also given a set of 23 criteria for SA to rank from the highest priority to the least important from a list of items concerning ageing successfully. The participants mentioned financial security and family support as the top priorities, and these components influenced health status indirectly. According to Hsu (2007), in the past older people would have been taken care of by their children, yet this filial piety relationship is changing drastically in Taiwan, causing the older adults to become concerned with respect to their financial needs in old age. Similarly, Romo et al. (2013), in their study among diverse older participants “with a late-life disability” using grounded theory methodology, found that SA involves subjective criteria and also has a cultural context that is not captured in objective measurements (pg. 947).

### **2.3.4 SA in the context of life course perspectives**

The adoption of life course perspectives has resulted in the SA model transitioning from one concentrating highly on biomedical conceptualisation to one in which SA is viewed in terms of the quality of the transaction between the changing person and changing society over the entire life course (Franklin & Tate, 2009; R. A. Pruchno et al., 2010; Schafer & Ferraro, 2012; Tam, 2014). The fact that human development is a lifelong process means that a person’s experience acts as an important form of guidance for their later life (Jinmyoung Cho et al., 2015; Crosnoe, 2002; Crosnoe & Elder, 2004; Elder & Johnson, 2002). A study conducted by Jinyoung (2015) among 375 centenarians and 54 proxy informants (45 centenarians and nine octogenarians), who were the spouses or children of the participants, suggested that SA models should integrate individuals’ past and current experiences. The study used structural equation modelling to analyse data from eight components: subjective well-being, physical functioning, physical and health impairment, cognitive functioning, social resources,

perceived economic statuses, education and past life experience. The findings also highlighted that high levels of social resources and education demonstrated positive effects in very late life. Some researchers have demonstrated associations between self-rated SA and other psychological domains through life course perspectives, such as resilience (Lamond et al., 2008), spirituality (Vahia et al., 2011), attitude and functioning (Phelan et al., 2004a). In a recent study, Vahia (2011) suggested an association between mental and emotional status and self-rated SA context, which mediates the positive impact of psychosocial protective traits such as resilience, optimism and self-efficacy. In a study assessing the determinants of self-perception of ageing and health among 291 community-dwelling older adults in Korea, it was implied that a lack of socio-economic resources and the previous existence of health issues leads to older people perceiving their ageing and health negatively. Hence, the researchers in that study suggested that the adverse effects of health problems owing to a negative perception of ageing could be reduced with the adoption of an optimistic view of health (Jang et al., 2004). As result of this, in a revised paper on their SA model, Rowe and Kahn (2015), encourage more studies in the field of SA that focus on the life course perspective.

### **2.3.5 Perspective on SA in diverse populations**

Another argument concerning the theoretical model of SA is that the concept has not been well studied among diverse populations (Laditka et al., 2009; Romo et al., 2013; Waugh & Mackenzie, 2011), with it having mostly been studied among Western populations (Iwamasa & Iwasaki, 2011; S. Torres, 2001; Sandra Torres, 2006). A perfect example of this scenario can be seen in the study conducted by Laditka (2009), which included 396 older adults aged between 60 and 75 years who were White, African, American, American Indian, Chinese, Vietnamese and Hispanic. In this study, themes of race/ethnicity were examined using the constant comparative method and notable differences and similarities were found in terms of the views of ageing well in diverse populations. This study therefore highlights the importance of information about differences and similarities among a variety of different populations, which can be of benefit to the creation of culturally sensitive messages to promote health. In agreement with Laditka (Laditka et al., 2009), the study conducted

by Romo et al.(2013) noted that various coping strategies were utilised to cope with a late-life disability by different race/ethnic groups.

There is clear evidence that the perspective of ageing successfully among Asian populations (in various studies conducted among Chinese communities) is unique to them and is influenced by cultural and subjective norms (Chong et al., 2006a; Chou & Chi, 2002; Hsu & Jones, 2012). However, Li et al. (2006) who conducted a study among the metropolitan community in Shanghai, China, found that the rate of SA is similar to that found in studies from Western countries. A study conducted among the older adults in an Asian community showed that ‘success’ in ageing means having a higher level of family support and financial security compared to its meaning among a Western community (Hung, Kempen, & De Vries, 2010). A cross-sectional study conducted among Hong Kong Chinese centenarians aged between 95 and 108 years by Cheung and Lau (2016) found that SA is not associated with biomedical criteria but rather is part of a multidimensional model. This study used multiple regression analysis to demonstrate that living with family members or friends, lower incidence of illness, the ability to participate in social activities and a higher level of optimism were independent correlates of SA.

Some researchers have claimed that cultural differences might alter the concept of SA (Fernández-Ballesteros et al., 2010; Matsubayashi et al., 2006). A study conducted by Fernandez (2010) set out to examine the similarities and differences in the lay concept of ‘ageing well’ in seven Latin American and three European countries and among younger (aged 50–64 years) and older (over 65) participants. The participants in the study were given a 20-item questionnaire on their ideas about growing old, as used by Phelan et al. (2004a) and Matsubayashi et al. (2006). The questionnaire was translated from English into Spanish, Portuguese and Greek. The study found one contrary item to the biomedical perspective on SA; greater longevity was not considered to be one of the most important components of SA.

The study above also revealed findings consistent with other studies of SA on lay elders who noted health, independence, social relationships and life satisfaction as the key components for ageing successfully. However, the study also pointed out that when the specific components of ageing well were identified, the stability that tends

to support the universality of the concept of ageing well across countries was diminished. Phelan et al.'s (2004a) study of several cultural groups comprising Japanese and White Americans also contributed to the awareness of having cultural differences as an important aspect in the measurement of the influence of the constructs of SA. In the survey the participants were examined on three components, including giving objective answers in a 'yes'/'no' format to a question asking if they ever thought about ageing and SA, and if this thought had changed over the past 20 years. In the next two sections, the study intended to investigate the components that were important to them by asking them to state which items were extremely important and which were not important from 20 listed items. In a later section, the participants were required to prioritise five important conditions out of 13 items selected from the previous list. This study highlighted the idea of an individual's changing thinking with regard to ageing successfully and also highlighted the differences and similarities between two racial/ethnic groups of people who shared the same living conditions. However, the list of items that were regarded as important for SA by the White Japanese did not match that of the original Japanese residing in Japan in a study conducted by Matsubayashi et al. (2006) that also used Phelan's survey. Similarly, in a study conducted by Torres (2001; 2006), immigrant Iranians in Europe assimilated certain cultural aspects of the Western population into their culture of ageing. Therefore, culture, perhaps more so than race, appears to be an important source of variance in lay theories of SA (Fernández-Ballesteros et al., 2010).

### **2.3.6 SA in the context of disadvantage and adversity**

There is growing literature posing the question of whether SA can occur in the context of disadvantage or adversity (Pruchno & Carr, 2017). Minimal research on SA has been conducted among vulnerable groups such as HIV patients and people with disabilities, thus demonstrating the need for a special focus. An exploratory study conducted among ten London-based HIV positive men over the age of 50, presented SA for this community as being highly associated with the challenges of growing older with HIV and the possibility of building supportive communities that are sensitive to the needs of older gay men (Owen & Catalan, 2012). Similarly, another qualitative study using grounded theory among 30 HIV-positive adults living in Ontario, Canada identified stigma and struggles to maintain health as impediments to SA (Emlet et al.,

2017). Buys et al.(2008) collected data using semi-structured interviews with 16 people with a lifelong intellectual disability aged 50 years and above. They found this group to have similar wants and aspirations to those of the broader ageing population. However, these people often encountered difficulties in achieving their wants and aspirations because of a lack of appropriate support or because of the controlling influence of others (Buys et al., 2008).

### **2.3.7 Recent development in spiritual transcendence domains**

In recent years, a further limitation of the theoretical concept of SA that has been highlighted is its lack of spiritual transcendence domains (Crowther et al., 2002; Mccarthy & Bockweg, 2013; Mccarthy et al., 2013; Sadler & Biggs, 2006). Crowther et al. (2002) proposed positive spirituality as an additional domain to Rowe and Kahn's model for SA. A systematic review conducted on 11 articles found that the feeling of being connected with transcendence and beyond the material world was found to be important to individuals who were losing their unique selves through a dementia-like illness (Agli, Bailly, & Ferrand, 2015)

As a result of these developments relating to the SA model, explicit evidence has been provided by recent studies that can be embedded within the SA model. For example, Depp and Jeste (2006) expressed the need to expand the primarily physical definitions to a wider definition that encompasses bio-psycho-social factors that are accepted by everyone (e.g. By clinicians, researchers and older people alike). In addition, there is the need for a multidimensional model such as that proposed by Phelan et al. (2004a) that considers all aspects of health including the physical, functional, psychological and social domains. Likewise, Stowe et al. (2015), in a review and synthesis of the literature on SA and studies that use a life course perspective, criticised the Rowe and Kahn model with regard to the personal control that influences one's later life outcomes and for its neglect of historical and cultural context, social relationships and structural forces in influencing later life functioning. Furthermore, Dillaway et al. (2009) recommended that researchers and clinicians be more careful when adopting SA terminology without understanding the potential socio-political consequences. In a nutshell, the conceptualisation of SA in terms of it being multidimensional and

incorporating the perspectives of lay people has been shown to be a more powerful predictor of quality of life compared to the simpler models (Bowling, 2006).

## 2.4 Systematic search of the qualitative exploration of SA among middle-aged adults

In view of the present study being aimed at the lay perspective of SA among middle-aged adults, the related works of literature conducted among middle-aged adults were assessed through a systematic search. The search strategy used category two (B) as presented in Figure 2-1 and yielded 11,841 articles (see Table 2-1). The eligibility criteria, aim, objectives and review questions of the studies included are explained in Table 2-2. The PRISMA flow diagram presented in Table 2-3 outlines the flow of the qualitative studies of SA conducted among middle-aged adults that were retrieved and either excluded from or included in the search.

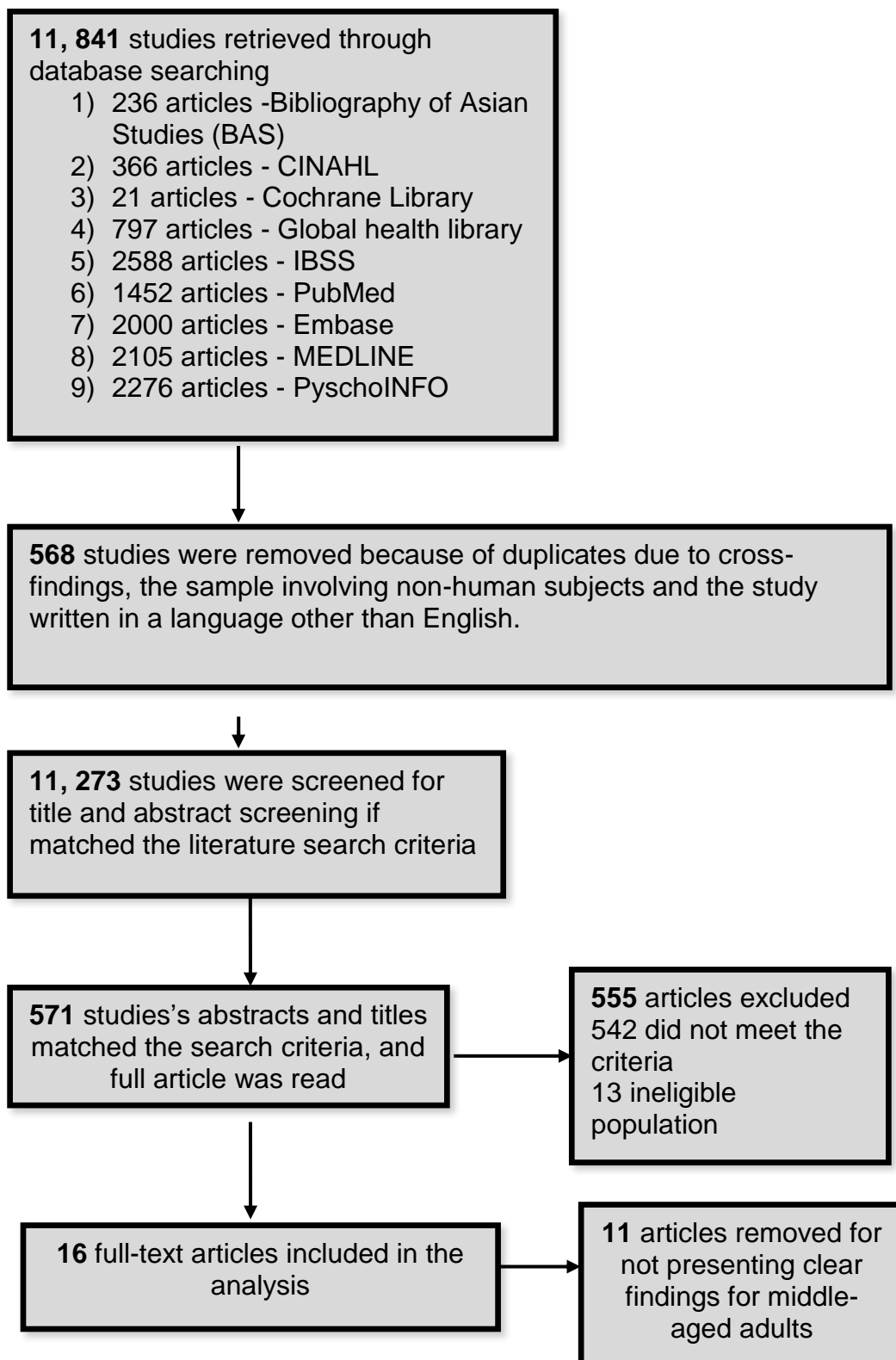
**Table 2-1: Number of studies retrieved according to search database**

Search database	Search dates	Total hit
Bibliography of Asian Studies (BAS)	1979-Jan, 2018	236
CINAHL	1946-Jan, 2018	366
Cochrane Library	1999-Dec,2017	21
Global Health	1931-Jan,2018	797
IBSS	1939-Jan, 2018	2588
Pubmed	2001-Jan 2018	1452
Embase	1883-Jan, 2018	2000
MEDLINE	1902, Jan, 2018	2105
PsycINFO	1900-Jan,2018	2276

**Table 2-2: Eligibility criteria, aim, objectives and review questions of studies included in the search**

No	Criteria
1	Published articles about the perspective of successful* (and other relevant terms) ageing* among middle-aged adults
2	English language
3	Qualitative studies
4	Human subjects
5	Participants aged between 40 and 65 OR mean age between 45 and 65
6	<p><b>Key aim:</b> To understand the perspective held by middle-aged adults about ageing successfully and to make practical decisions ahead of tackling ageing</p>
7	<p><b>Objectives of the review:</b></p> <ul style="list-style-type: none"> <li>• To analyse middle-aged adults' lay perception of ageing successfully across the published research articles.</li> <li>• To understand the criteria employed by middle-aged adults in defining desirable ways to age successfully.</li> <li>• To highlight the studies that have been conducted to understand the middle-aged adults' perspective of ageing and whether there is a need for future research.</li> </ul>
8	<p><b>Research questions:</b></p> <ul style="list-style-type: none"> <li>• How do middle-aged adults conceptualise SA?</li> <li>• Which outcomes are regarded as important aspects for ageing successfully by middle-aged adults?</li> <li>• How are internal (e.g. Psychological aspects) and external factors (e.g. Social, cultural, lifestyle, environmental aspects, etc.) Associated with successful ageing?</li> </ul>

**Table 2-3: PRISMA flow diagram of the literature search process for Item B in Figure 2-1.**



### **2.4.1 Studies retrieved**

This systematic search targeted studies conducted among individuals between 40 and 65 years of age to represent the definition of the middle-age stage of life in different countries (Craciun & Flick, 2014) (see Table 2-2).

However, a total of only sixteen articles met the criteria of the systematic search (see Table 2-3). Eleven articles were eventually excluded, thus giving a total number of studies included in the review of only five (see Table 2-3). Some thirteen studies were excluded due to their results presenting a mix of both middle-aged and old or middle-aged and younger adults, in which the understanding of SA specifically among middle-aged adults could not be established (Buys et al., 2008; Collings, 2001b; Fabbre, 2015; Hilton et al., 2012; D. S. Jopp et al., 2015; Owen & Catalan, 2012; Pietilä & Ojala, 2011; Tan, Ward, & Ziaian, 2010; Thiamwong, Mcmanus, & Suwanno, 2013; Waugh & Mackenzie, 2011). In these twelve studies, the researchers did not specifically explore the perspective of SA among middle-aged adults, and one study did not present the age of the study participants, describing them only as mature students (Zecevic et al., 2010). Therefore, only five studies were included in this review. Table 2-4 contains a summary of the five studies described.

**Table 2-4: Overview of the studies identified through the systematic search**

Author (s), Year	Study site, population descriptor	Age range /Mean age	Aim/Purpose	Method (s)	Results definition of SA and domain measurements
Bowling, (2006)	486 adults from Britain	50–65 years  (Only results from participants of this category of age included)	To explore the perceptions of positive ageing among middle-aged and older Hong Kong Chinese people, and to understand how they manage their personal, social and financial resources to strengthen their resilience and	Survey interviews with unprompted open-ended questions on perceptions: “What do you think are the things associated with SA?”  The open-ended questions were followed by a self-rating of SA, using similar questions to the Manitoba Follow-up Study: 1) “Would you say you are ageing successfully so far?” – A five-point Likert	Constructs of SA:  Health and functioning, psychological factors, social roles and activities, financial and living circumstances, social relationships, neighbourhood/community work and financial capacity/independence.  Most middle-aged respondents self-rated themselves as ageing successfully, thus suggesting that the presence of illness

			<p>adaptability in old age.</p>	<p>response category was designed, 2) “Why do you feel like this?”, 3) “How do you think getting older/ageing will affect you?”, 4) “Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?” A seven-point response category was designed, 5) “Do you have any long-term illness, health problems or disability which limit your daily activities or the work you can do?” 6) “In general, compared with other people your age,</p>	<p>should not be equated with ‘unsuccessful ageing’.</p> <p>Biomedical model of SA needs to be broadened away from illness and functional ability. The social models of SA, which used the simple term of quality of life, also need to be expanded.</p>
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				would you say that your current health is: “Excellent”, “Very good”, “Good”, “Fair”, and “Poor?”	
C.D Ryff., (1989)	69 community-dwelling adults from the United States	Mean: 52.5 (Only results from participants of this category of age included)	To probe middle-aged and older people’s conception of well-being	Interview reflected four main categories of enquiry.  The first set of questions dealt with general reflection and the participants’ lives. Questions asked: 1) “What was the most important to them in their lives at the present time?”, 2) “What they were unhappy about?” 3) “What they would like to change in	The middle-aged adults placed greater emphasis on career/job and family.  In comparison to older adults, the middle-aged adults gave a lower importance to health.  Activities such as social activities, church and volunteer work.

				<p>themselves or in their lives?”</p> <p>The second set of questions revolved around the participants’ past experiences as they were asked to describe their positive and negative experiences in their past and what they referred to as turning points.</p> <p>The third set of questions probed their positive psychology conditions. “How would you describe a person of their age who is well-adjusted, how would you describe someone mature, what is personal</p>	<p>Attitudes about life, faith, friendship and philosophy of life.</p> <p>Active self-improvement (e.g. Exercise, change personal habits), more accomplishments.</p> <p>Past experiences that were close to them temporally such as childhood problems and the death of a parent were accorded greater emphasis. Planned life events such as marriage, family and jobs.</p> <p>Conceptions of well-being: continued growth, enjoy life, being confident and</p>
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				<p>fulfilment and how would you describe an ideal person. What is immature, poorly adjusted and unfulfilled?”</p> <p>The last category was about the participants’ perceptions of the ageing process. The participants were asked how they had changed over the last 20 years, how they had stayed the same and what they thought were positive as well as negative changes associated with ageing.</p>	<p>assertive, self-acceptance and self-knowledge.</p> <p>Perception on ageing process indicated an awareness of change and stability in them over the past 20 years.</p> <p>Key challenge of SA is developing the capacity to accept life’s twists and turns, which may be progressively beyond one’s control.</p>
Harris, (2008)	2 Caucasian women from	61 (data from one middle-aged	To explore the concept of resilience in	Case study used person-centred approach	SA realised through:  Problem-solving skills

	the United States	individual in middle age extracted)	relation to ageing successfully among people with Alzheimer's disease		<p>Acceptance of changing self</p> <p>Positive self-concept</p> <p>Productive</p> <p>Fighting spirit</p> <p>Religious beliefs</p> <p>Social support networks</p> <p>Community resources</p>
<p>S. Torres, (2006) (2001)</p> <p>(Note: Although Torres has published two papers, they are based on the same data. Therefore, I</p>	30 Iranian immigrants in Sweden	35-59	To explore the context of migration whereby the culture of origin and host culture meet and how the pre- and post-migration	<p>Anthropological instrument designed by Kluckhohn and Strodtbeck. However, 12 new vignettes were added to make a total of 12 vignettes to elicit the differences in the Iranian perspective of SA that</p>	<p>The understanding of SA was regarded as a 'mastering of', 'surrendering to' or 'living in harmony with' attitude towards the ageing body.</p> <p>Experience of migration between cultures can</p>

<p>am counting them as one study in this review).</p>			<p>understandings of SA differ</p>	<p>were assumed to follow from the value orientation.</p>	<p>challenge the manner in which SA is understood. The tendency to change from Surrender to Master or Harmony was seen to make allusions to the process of migration. Those who reported a switch from a Harmony to a Master attitude towards the ageing body alluded to a maturity they gained after migration and how they understood the nature-related aspect of SA.</p> <p>The constructs of SA can be understood as time-related aspects: 1) Past – the importance of being content with what one has achieved</p>
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					<p>so far, 2) Present: assumes SA to be about living in the moment such as keeping a healthy balance between being goal-oriented and being able to live enough in the moment, 3) Future: SA is the continual attainment of goals.</p> <p>SA is also about having engaged or engaged less in activity as being acceptance of a deteriorating body.</p> <p>For those who held pre-migration understandings that differed from those they assumed to be found in the</p>
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					<p>host society tend to have changed to latter.</p> <p>Those who migrated before the age of 30 tended to show more change towards an understanding of ageing in the host society. SA also having engaged or engaged less in activity as being acceptance of a deteriorating body.</p> <p>For those who held pre-migration understandings that differed from those they assumed to be found in the host society tended to have changed to the latter.</p>
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					Those who migrated before 30 years old tend to show more towards change to ageing understanding of the host society.
Chong, Ng, Woo, & Kwan, (Chong et al., 2006a)	6 focus groups of people aged 40–59 years	40–59 years (Only results from the participants in this age category included)	To explore positive ageing among middle-aged and older adults in Hong Kong.	In-depth interviews	<p>Constructs of SA: good health, having a positive life attitude, active engagement with an activity or with society, feeling supported by their families and friends, being financially secure and living in a place with emotional ties.</p> <p>Key factors that enable positive ageing:</p> <p>Having a smooth transition from employment to full</p>

					<p>retirement, adopting a healthy lifestyle, thinking positively, promoting family and interpersonal relationships, building up financial resources</p> <p>Middle-aged recent migrants from Mainland China had high expectations of their children.</p>
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## 2.5 Uncertainty in middle age

Uncertainty is identified as an individual condition that results in an individual struggling to form a cognitive schema or an internal representation of a situation and outcome on account of a paucity of cues (Mishel & Braden, 1988). It can occur in situations such as illness and hospitalisation, with such events leading to worry and an inability to act (Buhr & Dugas, 2002). According to Brashers (2001), people face uncertainty “when details of the situations are ambiguous, complex, unpredictable or probabilistic; when information is unavailable or inconsistent; and when people feel insecure in their own state of knowledge or the state of knowledge in general” (Brashers, 2001, p. 478). Bradley and Drechsler (2014) highlight the classic decision theory, which distinguishes between situations of certainty, risk and uncertainty. Certainty is defined as when the consequence of an action is known. Risk, on the other hand, consists of the probability of a possible consequence of a known action, and it is not factual. Therefore, uncertainty is referred to as an unknown probability. A higher level of intolerance of uncertainty, or IU, is defined as ‘cognitive vulnerability’, the unknown and an inability to accept (i.e. Tolerate) an unknown and uncontrollable future (Prousky, 2016). For example, the demand to acquire additional information could be evidence of an intolerance for uncertainty and may aim at lowering the level of ambiguity (Buhr & Dugas, 2002) There are comparatively few studies on uncertainty related to ageing, with the few that there are having mostly been conducted among older populations and examined their coping behaviours in relation to risky situations. The studies, for example have addressed uncertainty among older people during events ranging from illnesses such as dementia, cancer, HIV etc. (Bailey et al., 2013; Bornat & Bytheway, 2010; De Guzman, Lacao, & Larracas, 2014; Owen & Catalan, 2012; Seppola-Edwardsen, Andersen, & Risør, 2016; Tanner, 2007a) and functioning and task switching.(Kray, Li, & Lindenberger, 2002) There are also studies that have looked at uncertainty among older adults associated with cultural and intergenerational uncertainty with ageing (Lamb, 2013) and knowledge about ageing (De Guzman et al., 2014).

Overall, there has been no study that has addressed uncertainty related to ageing in middle age, with the exception of some studies that discussed the outcome of health issues and their management in middle age. In a study among HIV patients ageing

with disability between the ages of 50 and 74 (mean age 56), sources of uncertainty were reported in six areas: 1) having a carer in the future, 2) appropriate long-term housing, 3) transition to retirement, 4) nature of illness (HIV), 5) knowledge of health care provider, and 6) financial domains (Solomon et al., 2014).

The studies on coping with uncertainty revolved around balancing risk and dealing with uncertainty through rationality (Zinn, 2008; Zinn, 2016). Coping activities with uncertainty from a daily perspective is socially shaped (Zinn, 2008). With lay people being the actors in everyday situations involving risk and probability and using reasoning to face them. The study highlighted the different rationalities used in different social processes, such as “hope, trust, faith and rational calculation” (Zinn, 2008, p. 447). A study conducted among middle-aged cancer survivors in urban Norway captured that the research participants balanced the uncertainty they faced after cancer by holding certain information from loved ones, avoiding unnecessary worries and through social support (Seppola-Edwardsen et al., 2016). Brashers et al. (2017), in a qualitative study among a control and intervention group of 98 middle-aged adults with HIV, found the intervention group managed uncertainty better than the control group. In the intervention activity, the participants participated in six sessions, with activities looking at both communication and information-seeking as resources for dealing with uncertainty in the control of their illness. The important strategies for coping with illness among these research participants were noted as taking control of the illness, social support and peer support (Brashers et al., 2017).

## **2.6 Care for the ageing in Malaysia**

### **2.6.1 National policy for older adults' care**

Malaysia is a multi-ethnic country with Eastern values and the majority of its population are from the Islamic, Hindu and Buddhist faiths. In 2018, the population is estimated to reach 32.4 million, comprising 69.1% Bumiputra (Malay), 23.0% Chinese, 6.9% Indian, 0.29% others. The population is made up of 52% males and 48% females. A total of 6.5% of the population is made up of older people aged 65 years and above (DOSM, 2017b) (see Chapter 1, Section 1.3.2).

The Malaysian National Policy and Plan of Action for Older People was reviewed in January 2011 based on an assessment made of an earlier national policy from 1995 and a Plan of Action for Older People formulated in 1998. This revised national policy aims at empowering Malaysians with a supportive environment and efficient care of older adults. Under the new policy, the Ministry of Women, Family and Community Development (MWFCD) acts as the Secretariat for the National Advisory and Consultative Council for Older Persons. Under this secretariat, seven ministries/agencies are involved in the coordination and implementation of activities concerning the older adults as part of nationwide programmes. These ministries are: 1) the Ministry of Health, 2) the Department of Social Welfare, 3) Ministry of Education, 4) Ministry of Housing and Local Government, 5) Ministry of Human Resources, 6) Economic Planning Unit, and 7) the Ministry of Science, Technology and Innovation. These members of the secretariat ensure activities for older people care are implemented through promotion and advocacy, lifelong learning, safety and security, governance and shared responsibility, intergenerational solidarity and research and development. The Ministry of Education is responsible for implementing a school curriculum to include education about care of older adults, including children's responsibility to show respect to older people. The Ministry of Human Resources will ensure the older people are encouraged to contribute to national development through training and skill empowerment. The Ministry of Housing and Local Government, on the other hand, is in charge of creating age-friendly recreation facilities and providing guidelines for housing that enable a safe and comfortable environment for older adult living. Recently, in 2017, the Malaysian government launched national guidelines for housing and town development. These include the development of towns that are age friendly and housing incorporating the new concept of 'multi-generation housing', in which the older adults are able to live close to their children (Ministry of Housing and Local Government, 2017).

At present, there are two prominent policies for older people care: The National Health Policy for Older Persons and the National Family Policy. The Ministry of Health has the duty to ensure that the older adults receive appropriate medical assistance in relation to health issues linked to ageing-associated decline such as long-term care in hospitals, psychogeriatric care, medical social welfare and interventions such as

screening and home visits. The public health screening has a target coverage of 5% of the older population (MWFC, 2014). The Ministry of Health is also in partnership with the Department of Housing to conduct enforcement on older people care homes to ensure they comply with the national guidelines. Under the National Family Policy, the MWFC has developed programmes to advocate ‘family well-being’ based on family and intergenerational values. Under this ministry community care provides support for older people who are independent but neglected by their family, and also for the older people who are both partially and fully dependent. Up to 2017, 11 homes for the older people– 9 *Pusat Rumah Sri Kenangan* and 2 *Rumah Ehsan* – have provided care for older people who do not have carers. As per the statistics for 2017, there are a total of 51 activity centres in operation throughout the country focusing on interventions for older people. The older people who are disabled and require assistance are able to apply for monetary aid amounting to RM 300.00 (approximately £55) to employ some hired help. There are also other national initiatives in place such as home help services for older people living alone, services to transport older people to hospitals/clinics and welfare support for the needy (Department of Social Welfare, Extracted in November, 2017)

### **2.6.2 Legislation pertaining to older people**

There are a few laws that are not specific but are related to older people and protect some matters concerning the older people. These include the following:

- 1) Employment Act 1995 – protects older people benefit
- 2) Will Act 1959 – increase awareness and guidance for will writing
- 3) Employees’ Social Security Act 1969 – provides contingency aid upon entering retirement
- 4) Employee Provident Fund Act 1991 – Withdrawal after retirement withdrawal from the contributions made to Employee Provident Fund (EPF)
- 5) Care centres Act 1993 (Act 506) – Allows inspection of care centres
- 6) Domestic and Violence Act 1994 – No particular statute for older people abuse but provides legal protection against domestic violence, including for older people as members of a household.

- 7) Persons with Disability Act 2008 – provides protection and rehabilitation for disabled people, including older persons
- 8) Mental Health Act 2001 – Provides care, treatment, rehabilitation and protection of persons with mental disorders and related matters.
- 9) Malaysian Health Promotion Act 2006 – advocates for and promotes ageing-related information through media and national campaigns.

The Ministry of Women, Family and Community Development has implemented a national plan for older people guided by short-term, medium-term and long-term strategies. These strategies include creating public awareness of issues related to ageing, enhancing collaboration with NGO and strategic partners, forming policies related to ageing, and creating a supportive environment and infrastructure among others (MWFCD, 2010).

## **2.7 Defining the knowledge gap for policy, intervention and initiatives related to the ageing population**

The breath of this literature review suggests that knowledge and action about success in ageing needs to be multidimensional and include both objective and subjective measures. However, the literature is limited in the extent to which it provides a clear description of the factors that relate explicitly to middle-aged adults from an Asian background. Although there has been wider study of ageing and SA conducted among Western populations and in the context of developed countries, recent years have seen relatively fewer studies conducted among Asian populations. However, it is noted that these studies have been mostly carried out among Chinese or Asian populations residing in developed countries.

There is a lack of understanding with regard to ageing in the context of life course, which has resulted in the overlooking of a complete description of the issues and factors in midlife that underline the ageing experience in later life. From the systematic search undertaken, a total of only five qualitative studies were identified as having examined the lay perspective of middle-aged adults. There is thus a lack of information from the actual social actors who are the direct experiencers. This has also resulted in a lack of knowledge of how life course experiences, including past experience and

future expectations, shape individuals' knowledge of ageing successfully. The literature highlights that individuals will change over time and that such change contributes to the ageing self. All of these factors are likely to have a significant impact on the perspective of SA.

Furthermore, only limited amount of specific care is currently made available to the older population through the policy and national programme in Malaysia. Therefore, in conducting this qualitative research I have sought to contribute to the wealth of knowledge and to contribute new insights to the realm of SA studies.

## **2.8 Key message**

The literature review in this chapter outlines the context of SA with the aim of understanding its theoretical concept. The findings of the literature review suggest that there is a lack of knowledge about the actual experiences of middle-aged people with regard to SA; the research study, which follows, will address this gap. Consequently, understanding the phenomenon of ageing among this social group is significant for recognising areas of improvement and in order to minimise the gaps in the existing models of SA.



## **Chapter 3 : Methodology**

This chapter details the methodological stance of this study. It begins with the research aim, objectives and questions. The design underpinning the research are highlighted next. The chapter then proceeds to detail the methodological consideration and research design. The research process, which comprises methods including sample selection and recruitment, ethical consideration, data collection and the actions that were taken to ensure the rigour of the study, is examined. Next, the chapter covers the data analysis and synthesis, as well as the challenges encountered and reflection on the research process. Finally, the conceptual model from the data analysis of the current research is highlighted.

### **3.1 Research aim and questions**

The main aim of this research is to explore how middle-aged Malaysian adults conceptualise successful ageing and the implications of this for their anticipated behavioural change.

#### **3.1.1 Objectives**

1. To identify the concept of the ageing self, according to middle-aged Malaysian adults;
2. To explore the normative beliefs, societal norms and reported external and internal barriers to achieving SA;

The below aim was formulated following the findings obtained from the Phase 1 data collection and was the focus of the theoretical sampling:

3. To understand the experience, priorities and supports needed to cope with the uncertainty that impacts-on the successful ageing process amongst middle-aged adults.

#### **3.1.2 Research questions**

1. When do middle-aged adults perceive the beginning of old age?
2. How do middle-aged adults conceptualise SA?

3. How are internal factors (e.g. Psychological aspects) and external factors (e.g. Social, cultural, lifestyle, environmental aspects) associated with SA?

The research question below was identified in line with the third aim mentioned above.

4. How do middle-aged adults cope with uncertainty with a view to increasing their well-being in later life?

In the following section, I detail the overall strategy adopted to integrate the research problem, data collection and analysis of the data. This section will enable the research problem to be identified logically and will assist in the avoidance of ambiguity in the process of data collection and analysis.

## 3.2 Research design

A research paradigm consists of the following components: ontology, epistemology, methodology and methods (see Figure 3-1).

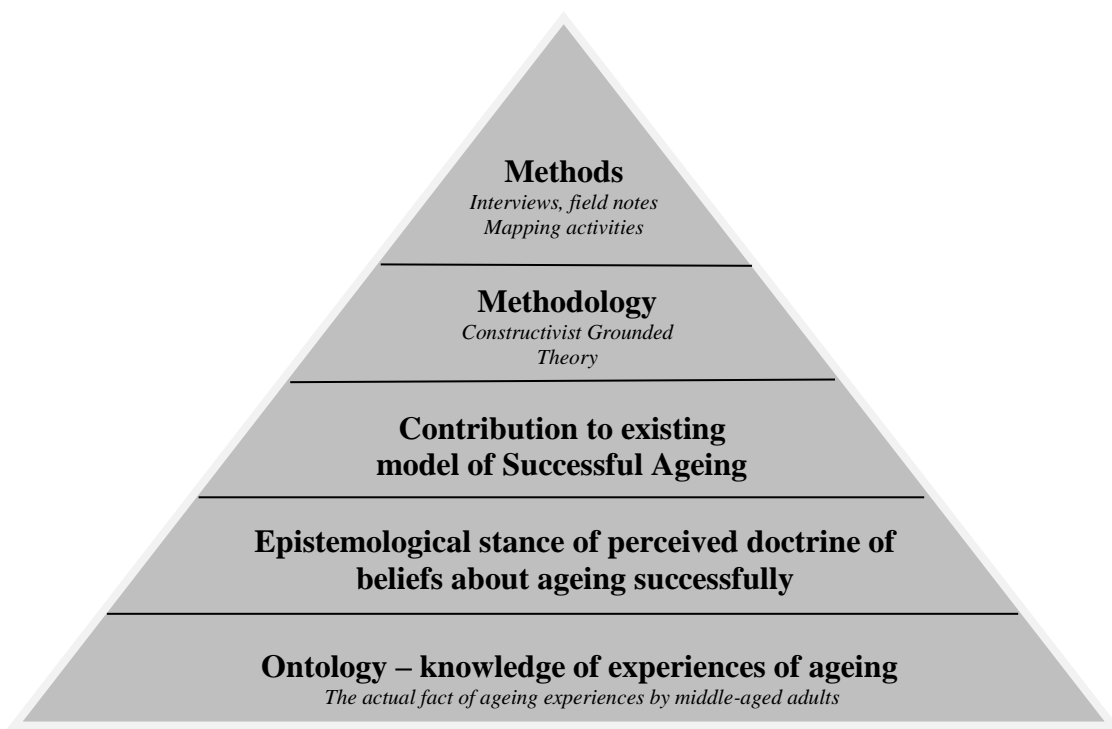


Figure 3-1: Overview of the research design

The above pyramidal diagram representation consists of five layers that seek to explain the design of the current research. The first, bottom, layer describes the ontological consideration of what is known as the social phenomenon of ‘ageing’ and its context among middle-aged adults. The second layer comprises the epistemological stance, which is the perceived set of beliefs relating to the knowledge of how people in midlife intend to age successfully and also the factors that are associated with the behavioural intention for ageing.

Moving on to the middle layer of the pyramid, where the theory sits, and a substantiated explanation about how middle-aged adults increase their well-being to achieve SA in the future is outlined. In this study, the acquired knowledge relates to how the participants make sense of the meanings of the events that have taken place in their lives and their actions in relation to ageing successfully (Bryman, 2004a). Hence, the conceptual model that emerges from this study seeks to contribute to the existing body of knowledge about ageing successfully.

The top layer of the pyramid contains the methods in accordance with the methodology employed. It outlines the approaches that are integrated with qualitative techniques for collecting and analysing the data. The participants were interviewed twice. In the Phase 1 interview, the participants were interviewed using semi-structured questions, with the findings from these data influencing further data collection through theoretical sampling (see Section: 3.4.1). Subsequently, in the Phase 2 interviews, data were collected through three activities and were analysed and combined with the findings from the Phase 1 interviews (see Section: 3.4.2). In activity 1 of Phase 2 interviews, the participants highlighted the prominent factors identified as contributing to an individual becoming old. In activity 2, the participants discussed the priority accorded based on timescales to the activities mentioned for dealing with uncertainty. The discussion section of the third activity used vignettes, whereby the participants discussed the actions taken for coping with uncertainty, as highlighted in the Phase 1 interviews. The methods utilised in this research study are outlined further in Section 3.3. In the next section, the ontology and epistemology that underpin the study’s phenomena will be discussed in turn.

### **3.2.1 Ontology and epistemology of the current study**

Ontology is the study of being; it is concerned with ‘what is’, with the nature of existence (Crotty, 1998, p. 10). In contrast, epistemology concerns the basic or inherent features of a phenomenon and the construction of knowledge. It is the relationship between the ‘knower’ – the knowing person who is in contact with the actual situation (Greene, 1966) – and what can be known (Guba & Lincoln, 1994). Ontological and epistemological views are both fundamental ways in which a researcher acquires knowledge and establishes what ‘counts’ as knowledge in that field, at that time. These elements provide the means of acquiring and potential to establish the truth that will influence the research that the researcher is conducting (Egbert, 2014).s

There are two basic approaches to research - positivism and interpretivism/constructivism. Positivism is an approach to research that acknowledges the existence of objective reality. In positivism studies, the ontological position is that the phenomenon of research has “an existence independent of the knower” (Cohen, 2018, p. 5). The researcher is thus expected to be emotionally detached and uninvolved with the object of study (Johnson & Onwuegbuzie, 2004). As a result, the positivist epistemology is objectivism; and the researcher and research are independent entities (Scotland, 2012).

On the other hand, the ontological position of interpretivism/constructivism is relativism in which phenomena are viewed as being subjective and constructed by the individual (Frowe, 2001). Relativists perceive, therefore, the reality of multiple individuals as shaped by history and cultural context, which, in turn influence their perspectives about the world. Hence, relativists deny the existence of an objective reality (Mills, 2006; p 26). It “does not exist independently” from the researcher (Grix, 2010, p. 83). The focus of the epistemological stance of constructivism is the subjective interrelationship between researcher and participant and the construction of meaning at hand (Hyes & Oppenheim, 1997; Pidgeon & Henwood, 1997).

The researcher of the current study aimed to build an understanding of existing conditions and construction of knowledge as it is held by society. In this current study,

therefore the underlying ontological assumptions are related to perceptions of ageing in light of Malaysian middle-aged adults' beliefs, life experiences and attitudes. Malaysian culture, as with other Eastern value systems, teaches people that making sacrifices for family wellness is positively associated with personal well-being. People with these characteristics develop a sense of belonging to society because they meet the societal expectation. This reflexivity and the researcher's own awareness and experiences contribute to the researcher's (my) belief that 'collectiveness' is the important context in the ageing experience among the Malaysian community. Although some of the practices or values of the research community may have disappeared or become assimilated with modern practices, I believe that the foundation of their actions (e.g. Beliefs, behaviours, and spiritual practices) continue to be based on the pre-existing system. Therefore, I use a constructivist approach because I believe there to be an existing culture and set of values embedded in the society in which we live (Crotty, 1998, p. 58). The core knowledge studied in this research is therefore is the exploration of meaning for successful ageing held by the research participants through their beliefs, behaviours and practices.

### **3.2.2 Positivism vs. Interpretivism/Constructivism**

Ageing studies have been conducted in various research paradigms (e.g. Scientific/positivism, post positivism or interpretative). From a positivistic and post-positivistic perspective, scientists continue to find evidence for the causes and effects and target treatments for the deterioration of our bodies caused by ageing (Depp, Harmell & Jeste, 2014; Mehdi et al., 2017). From an interpretative standpoint and mostly in socio-cultural and anthropologist studies, social scientists have conducted enquiries into how humans interact with the ageing process and have interpreted their behaviours, with the results then used to assist in the development of preventions and treatments from a humanistic perspective. Examples of such studies include a study by Pollitt (1996) on dementia in old age, and a study by Gheorghita (2016) on the perspective of ageing through an anthropological lens.

Positivistic investigations feature highly in quantitative studies in contrast to interpretative studies that are mostly conducted within a qualitative paradigm. Qualitative methods are thus highly concentrated on the subjective, the natural

behaviour of people and perceptions of the social world (Denzin & Lincoln, 2005, 2011, 2017). On the other hand, quantitative methods have focused greatly on the objective of reality.

There are studies that use both the qualitative and quantitative approaches to conducting ageing research. The sociology research using qualitative exploration includes methods such as interviews, narrative and observation, etc. (Lub, 2015; Santiago-Delefosse et al., 2015). In contrast studies in the positivist paradigm have an emphasis on the medical investigation of disease and treatments (e.g. Diagnostics, experiments, survey etc.), are carried out using scale and inferential statistical tests and yield a reasoning of the truth of a phenomenon by using quantitative methods (Rossi, Bramanti, & Moscatelli, 2015; Schacter, Gaesser, & Addis, 2013). The following sections will explore in detail the background of GT, CGT and the influence of symbolic interactionism.

### **3.2.3 Grounded Theory**

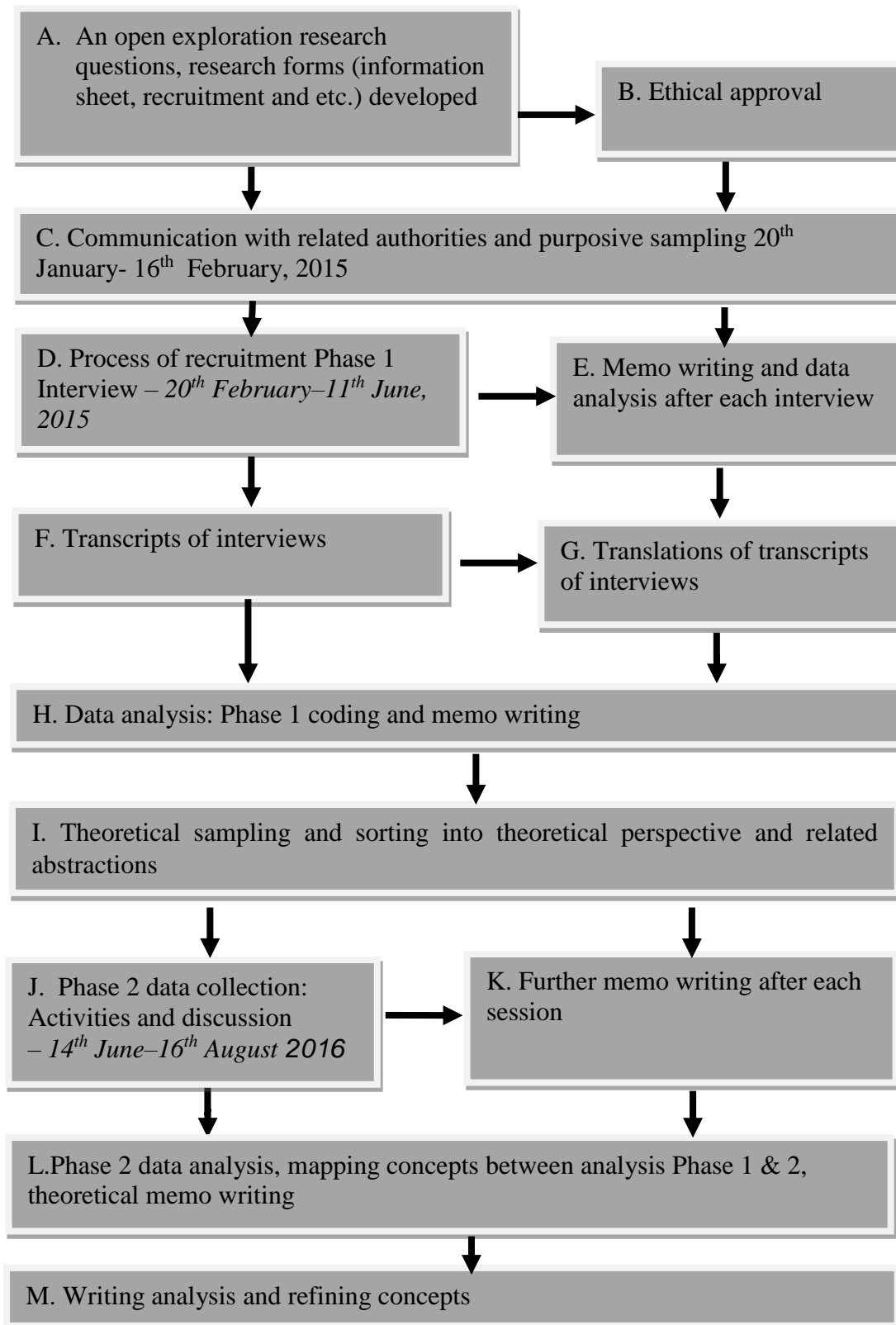
Strauss and Glaser were the first to develop the Grounded Theory (GT) approach in the 1960s (Glaser, 1967; Mello & Flint, 2009; Ong, 2012). They combined the exactness of statistical methods with the looseness of the theory-generating style. The data collection is inductive in nature which means the researcher has no preconceived idea but constructs meaning while the data being collected (Mills, 2006). However, in the early 1990s, Glaser and Strauss developed their own independent schools of thought: Glaserian GT and Straussian GT (Lauridsen & Higginbottom, 2014a). As its ultimate aim, the GT method seeks to discover and understand the meanings and concepts used by people in a social setting. Glaser proceeded to generate an evolved form of GT, producing a reformulation of the classic model that viewed the research as being separate from the researcher (Barnett, 2012). Following this difference in approach, Strauss co-developed his own version of GT with Juliet Corbin, who advocated the reconstruction of a theory that is richer and more reflective of the context (Strauss & Corbin, 1997a). Both of these traditional GT models require researchers to engage in an enquiry with no preconceived ideas. They are therefore more inclined towards a positivistic position.

Over time, however an increasing number of research studies have employed GT methods. The original GT of Strauss and Glaser became diversified, notably when Charmaz formed a new perspective of GT. The differences lay in the diversity of the philosophical stances held by Glaserian and Straussian GT. Charmaz's new approach, however, was aligned with the original precepts of GT, yet she visualised it from an alternative ontological and epistemological perspective. This led to the formation of the second-generation school of GT called 'Constructivist Grounded Theory' (CGT) (Amsteus, 2014; Charmaz, 2014b; Higginbottom & Lauridsen, 2014). GT, therefore, is a dynamic methodology that has moved from post positivism (Glaser, 1967) to symbolic interactionism, pragmatism (Strauss, 1990) and constructivism (Charmaz, 2008) and which offers ontological and epistemological perspectives at specific moments in time (Ralph, Birks, & Chapman, 2015).

GT can systematically unveil the phenomenon of interest in its natural setting and at the moment that something has taken place, thereby making this methodology the most widely employed framework for analysing qualitative data (Bryman, 2015; Goldkuhl & Cronholm, 2010; Thornberg, 2012) from healthcare research to other fields (Dey, 1999; Mccallin, 2003; Mccann & Clark, 2003; Thornberg, 2012). It has been used, for example, in the fields of management (Jones & Noble, 2007), business (Sternquist & Chen, 2006), information and technology (Coleman & o'connor, 2007) and logistics (Mello & Flint, 2009).

Thus, taken from the standpoint of the GT paradigm, the researcher can establish a theory, which can be used to provide an explanation of the underlined phenomenon from the point of view of its social actors. Figure 3-2 below shows the study design stages, beginning with the research questions and moving through purposive sampling, initial interviews and theoretical sampling, memo writing and, finally, data analysis.

The present study employs CGT, which is a version of GT developed by Charmaz to enhance understanding of the social (e.g. The culture and life lived by a person) and psychological (e.g. The individual's behaviours, emotions and feelings) aspects. At the same time, it also helps to address what is actually happening in the community. The following Figure 3-2 presents an illustration of the current study design based on Charmaz's Grounded Theory.



**Figure 3-2: Illustration of the study design based on Charmaz's Grounded Theory (2014a)**

### **3.2.4 Reasons for adopting qualitative design**

There are five distinct reasons that serve as the rationale for adopting a qualitative design for this research study.

Firstly, the paucity of literature explicit to the Malaysian context means that the perspective of successful ageing among this population is unknown. Some Malaysian local researchers have also highlighted this concern in their studies and voiced how the topic of individuals' preparation for ageing and the prospect of getting old are not widely discussed among the Malaysian population (Ambigga et al., 2011; Arokiasamy, 1997; Poi, Forsyth, & Chan, 2004). This somewhat scant existing knowledge with regard to the midlife perspective of ageing may therefore lead to a lack of understanding of the phenomenon in the local context and may also result in failed interventions. According to Egbert (2014), an individual perspective is defined not only by values and perceptions but also by the sum of one's experiences, beliefs and knowledge from every facet of life. Gender, for example, and the religious, family, political, social, academic and environmental arenas are all important in the study of population (Egbert, 2014). Particularly when little is known about the phenomenon of interest (Mello & Flint, 2009). An in-depth exploration would therefore assist in building an understanding of both the subject/actor's interaction and the surrounding factors.

Secondly, an extensive proportion of the literature is focused on older adults who are already experiencing the process of ageing as people in 'middle old age' (70 to 79) and 'oldest old age' (80 and above). This is a time when individuals tend to display the greatest variability in their health and cognitive function. Only a handful of studies so far have focused on middle-aged people (Bowling & Iliffe, 2006; Charbonneau-Lyons, Mosher-Ashley, & Stanford-Pollock, 2002; Chong et al., 2006b; Collings, 2001a; Hilton et al., 2012, Ko et al. 2007; Ryff, 1982; Sandra Torres, 2002; Waugh & Mackenzie, 2011; Westerhof, Dittmann-Kohli, & Thissen, 2001), and these have also mostly been conducted in the positivist research paradigm.

Thirdly, considering that the current study concerns narratives of life in later age, it includes the participants' experiences, beliefs and behaviours that have influenced

their actions to age successfully. A study by Reichstadt et al. (2010) identified that older adults' perception about what is successful ageing about self-acceptance and self-growth contributed by past experience. I therefore believe that a qualitative model would be an appropriate research design as this approach is exploratory, allowing all aspects of the participants' lives and influences to be explored. Moreover, this research might also observe the cultural context underpinning the process of ageing in the given community. Hence, the participants' narratives of specific experiences and events in their life are essential to the understanding of the phenomenon being studied. Narratives also help to unveil the complexity of the behaviours that are presented in the current studied community.

Fourthly, in reflection of the fact that people act and react differently to the ageing process based on their perceptions or the meanings they create between themselves and the world that they share with others, qualitative analysis could help to gain a deeper understanding of the meaning of ageing successfully. The comprehension of a phenomenon depends on an individual's perception, in which the meanings of the situation occur through "communication between a human and their world" that is developed and transmitted through a social context (Crotty, 1998, p. 42). Moreover, the world cannot be entirely discovered through empirical research alone; there must also be theory development that is based on the knowledge and experience of the researcher (Della Porta & Keating, 2008). Interpretative theory is inductive and grounded, generated from the data and not preceding it (Cohen, 2018). When individuals' views of the ageing experience are accumulated, it becomes possible to understand what is actually occurring in a community. Therefore, it is difficult to acquire a comprehensive knowledge about people without the researcher having a close understanding of their research participants' reaction in a particular situation.

The researcher, therefore, needs to be close to the data collected by having a good relationship with the participants and striving to understand the meaning associated with their actions rather than obtaining formulated responses. Nevertheless, the findings reflect how the data have been collected and through whom, in addition to how the meaning from the data has been constructed between the participants and the researcher. Therefore, it entails two-way communication between the researcher and

the research participants (i.e. Through the meaning they are giving by their actions and their experiences from day-to-day life). Moreover, the participants are also able to benefit from the research through being able to discuss the problems they face in relation to ageing and the actions that they need to take (Creswell, 2013).

Finally, reflexivity is an important part of the qualitative paradigm and is concerned with community dynamics (e.g. Collaboration, power presentation and reflexivity) (Flicker et al., 2007; Flicker et al., 2008). Qualitative study thus provides a route to robust exploration of a phenomenon and moves towards a focal interpretation of that which is actually contributing to the phenomenon, not through the actions of researchers independently but through them working together with the research participants.

Since this study explores the perspectives of ageing, it does not stand in isolation from the contributions made by its subjects or actors; rather, the experiences of ageing could be located with circumstances through interpretative exploration. As mentioned above, individuals observe and provide an account of a phenomenon as they experience it; therefore, a phenomenon cannot be assessed through objective measurement alone. In other words, knowledge is subjective and contextualised through personal experience and is not acquired or imposed from the outside. Moreover, language and prior knowledge (history) serve as mediators for individuals' courses of action (Egbert, 2014). The information sharing by surroundings, meanings created about situations and experiences are actually the guiding factors of actions performed by people. To conclude, I believe there to be a perceived set of beliefs about the nature of knowledge on the meanings that people attribute to SA in this study, thereby rendering it appropriate to utilise a qualitative approach as a research paradigm. Grounded Theory Methodology (GTM), specifically a Constructivist Grounded Theory (CGT) approach, was chosen as the best fit for the current study.

I assessed a number of methodological approaches to study the perspective of ageing prior to selecting CGT. For instance, phenomenological and ethnographic approaches have been used extensively in qualitative research studies. However, I rejected these approaches since their nature of enquiry does not match the aims of the present study. For instance, phenomenology is the study of the consciousness of everyday lived

experience to understand the subjective experiences of people (Mello & Flint, 2009). However, when taking a descriptive phenomenological approach, the preconceptions of a phenomenon are suspended prior to commencing the research to ensure a neutral approach to the topic (Davidsen, 2013). Sharing the same cultural background as the research participants, I therefore have some basic ideas of the ways in which they live within the existing community (see Section 3.2.4).

Ethnography aims to provide a description and interpretation of the culture and social structure of a social group (Mello & Flint, 2009). The phenomenon and its actors would therefore need to be studied for a long period within the natural setting in which behaviour occurs (Robson, 2016). This approach is primarily based on observation and secondarily on interviews (Mello & Flint, 2009). This means it goes beyond participant observation since an ethnographic study covers the complete circle of life and includes supplementary data (e.g. Documents, diagrams, maps, photographs) and occasionally formal interviews and questionnaires (Charmaz, 2010). Although day-to-day practices underpinning the perceptions of ageing need to be explored in this study, its primary focus is the factors that influence the practice of successful ageing. I have also been awarded a scholarship to conduct the present study as part of my PhD research; as such, the ethnographical method may impose constraints on finishing on time, which in turn may also affect my scholarship funding.

### **3.2.5 Other theoretical influences**

The current research is also shaped by Symbolic Interactionism and the Theory of Planned Behaviour (TPB). These two theoretical frameworks provide an understanding of the phenomenon under study; the behaviour of successful ageing among the research participants. The background of these theoretical frameworks and their influence on the current research are discussed in turn.

#### **3.2.5.1 Symbolic Interactionism**

Symbolic Interactionism is associated and embedded within the theoretical perspective and foundations of GT (Chen and Boore, 2009). This perspective has its origins in the pioneering work of Mead (1863–1931), who was a social psychologist in the early 1900s. Symbolic interactionism is both a theory of human behaviour and

an approach to enquiry into human conduct and group behaviour (Goulding, 2011). With Strauss' bringing of logic and its assumption of symbolic interactionism into the formation of GT, it has become part of the method (Charmaz et al., 2007).

According to Blumer (1969), symbolic interactionism rests upon three premises:

1. Human beings act towards things on the basis of the meanings that the things have for them;
2. The meaning of such things is derived from the social interaction that one has with one's fellows; and
3. These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters.

In recent years, Charmaz (2014a) has posited additional premises that clarify and extend Blumer's position, as follows:

1. The meanings are interpreted through shared language and communication;
2. The mediation of meaning in social interaction is distinguished by a continually emerging process of nature; and
3. The interpretive process becomes explicit when people's meanings and/or actions become problematic or their situations change.

The above premises thus clarify how the meanings are linked to practice. The study of society is about collective actions, which are actually undertaken by individuals (Ong, 2012). Therefore, individuals consist of social worlds, but individuals also commonly act as part of or on behalf of their social world (Strauss & Corbin, 1997b). People act according to their environment, society's appraisal and the beliefs that they uphold. They therefore interpret their activities both individually and together in order to understand and make sense of their behaviours, attitudes and norms.

In addition, people construct new meanings or reconfirm past meanings through their practices. However, when problems arise and events are interrupted, the meaning created might need to be reassessed. As our social life is evolving, people learn and absorb routine meanings and practices through their affiliations. They are unlikely to

change their practices or meanings unless their situations become problematic or their habitual responses unable to produce result in issues (Charmaz, 2014a).

However, our experiences and the meanings we attach to them will change as our experiences also change (Abrell & Hanna, 1978). Nevertheless, these subjective meanings are not private but rather inter-subjective since individuals to some extent share their thoughts and behaviours that are collective and permeate their subjectivity (Blaikie, 2009; Ong, 2012). Moreover, for behaviours that are considered to be socially significant or 'true', an individual might seek social recognition or acknowledgement through performing the accepted practices and norms. This would permit them to integrate socially (Strauss & Corbin, 1997a). In any given society, including in Malaysia, culture and social norms are two important elements. Malaysians, like others, tend to perform behaviours that are defined by custom, identity, tradition and values or rules, which are in turn defined by the social norms within the society.

Symbolic interactionism is therefore a dynamic theoretical perspective. It views people as active beings who are engaged in practical activities in their worlds, and it focuses on how they have accomplished these activities. Through this perspective, it is recognised that human beings respond to a situation such as ageing with an interpretation of what it is, developed through interaction from previous events or future encounters. Notably, symbolic interactionism inspires theoretical-driven research and the GT method offers the analytical tools with which to undertake it (Charmaz, 2014b).

Within the context of this research, the premises of symbolic interactionism can be understood as follows and they serve to initiate a theoretical-driven research study:

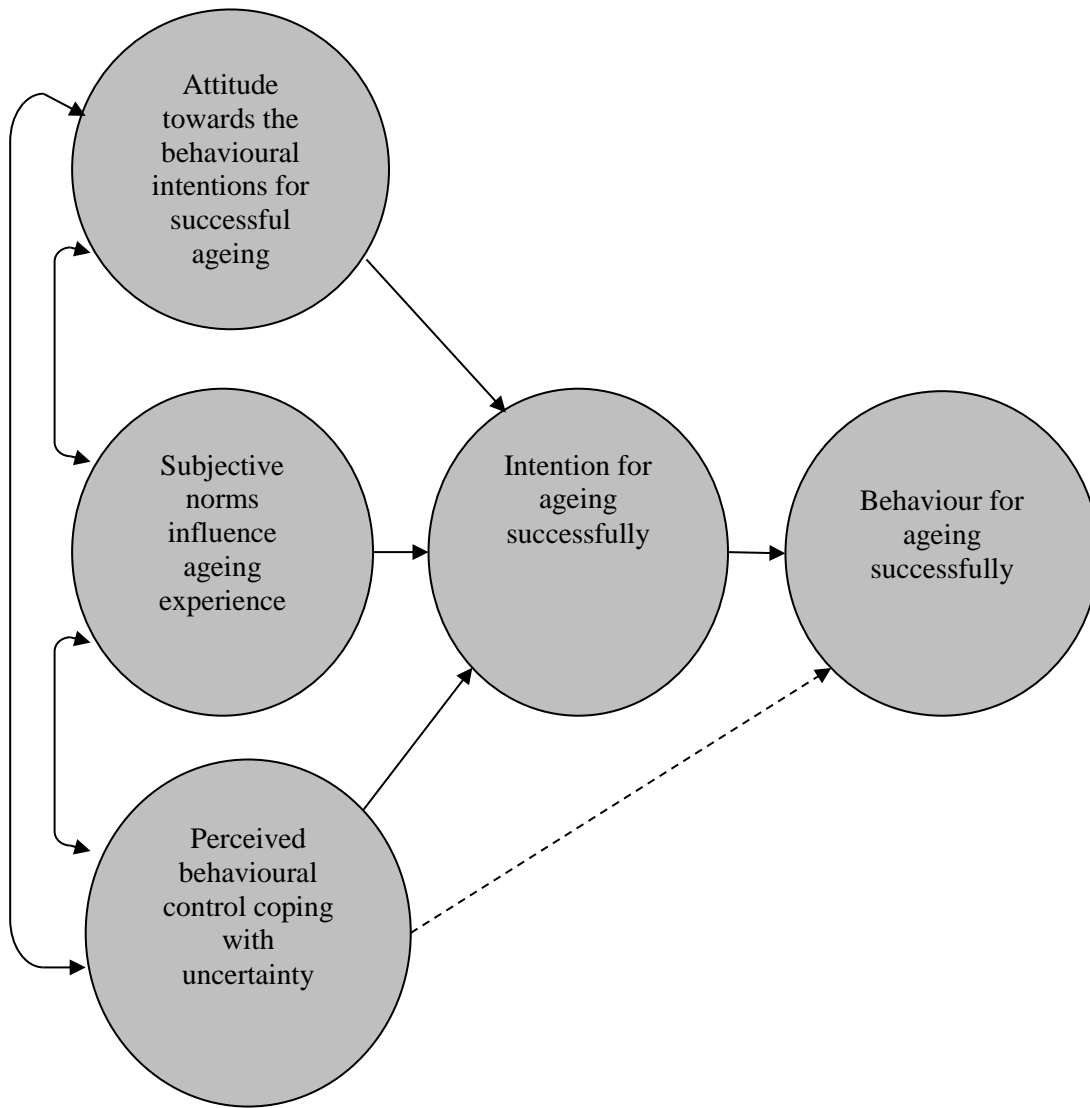
1. The concept of ageing successfully is influenced by the meaning of ageing itself that is held by middle-aged adults.
2. The perception of ageing successfully might be based on the social norms recognised by other individuals in the society.
3. Meanings are handled and altered through an interpretative process, which could include values exchanged between 'previous' and 'new' generations and the problems or risks encountered.

The theoretical foundations drawn from symbolic interactionism are relevant to the present study as the perception of old age is constructed within a participant's self, situation and society (Charmaz, 2014b). The approach deliberately focuses on how people interpret and create meanings of ageing from the events and symbols that they use to convey them (Baker et al., 1992).

### **3.2.5.2 Theory of planned behaviour (TPB)**

The data collection through prompt sheet used in this study interview was partially influenced by elements of the Theory of Planned Behaviour (TPB), which was developed by Ajzen and Fishbein in 1985 for collecting data in an open context (see Appendix 17), but with explicit research questions. Elements of the TPB model were used to form open questions for use in the current research as Malaysian adults might have specific beliefs, intentions and behaviours for ageing successfully. Numerous examples generated from this perspective have suggested that different populations report different beliefs for similar behaviours (Bocksnick, 2004; Luo, 2012).

As shown in Figure 3.4, the TPB postulates that one's intention to perform a behaviour and its actual performance are determined by three conceptually independent constructs: attitude towards the behaviour, subjective norms and perceived behavioural control, which together lead to individuals' behavioural intention and the behaviour itself (Ajzen, 1988; Fishbein, 2009)



**Figure 3-3: Modified from the Theory of Planned Behaviour (Ajzen 1988)**

Attitude is an individual's overall positive or negative evaluation of performing the behaviour, through the experiences they encounter. It takes into consideration their beliefs about the consequences of performing the behaviour and an evaluation of these consequences (Mishra, 2014). In contrast, subjective norms are based on beliefs that are associated with the referent where an individual or group approve or disapprove of the performance of the behaviour. For example, the referent for a particular behaviour towards the ageing process could be peers, family members, colleagues, the community at large or even an acquaintance. Thus, the extent to which the person is motivated to comply with those referents is weighted by the beliefs (Ajzen, 1988; Fishbein, 2009). In a country like Malaysia, which has a collectivist culture, social norms are considered to be a significant way of viewing the life of people.

Perceived control is based on beliefs about the factors that make performing the behaviour either easy or difficult. The broken line in Figure 3.4 indicates that the link between perceived behavioural control and behaviour is expected to be formed only when there is some agreement between the person's perception of control and their actual control over the behaviour. According to Ajzen (1988), these beliefs may be based on past experiences of behaviour, but they will also usually be influenced by second-hand information (e.g. Information from peers, the media, society, etc.) About the behaviour carried out by others. Given the level of resources (e.g. Time, money, skills), intentions can be changed and the greater the resources, the more likely that unforeseen events will produce changes in intention.

As suggested by the TPB, the more positive the attitude towards ageing and the greater the perceived behavioural control, the stronger the individual's intention to perform the behaviour might lead to successful ageing. In order to understand people's behaviour as being motivated by attitude, norms, barriers and motivation to perform behaviour for ageing successfully, the participants were asked the following three questions (see 3.4.1):

1. What are the aspects that motivate you towards ageing successfully?
2. How do you intend to age successfully?
3. How do you see yourself being challenged to age successfully?

### **3.3 Method**

A methodology is “a plan of actions” and incorporates the “choices and practices of specific methods” (e.g. Techniques and procedures) to analyse data (Crotty, 1998, p. 3) and to discover knowledge (Scotland, 2012). The methodological assumption is related to the epistemology of how researchers find out what they believe can be known. In Sections 3.2.1 and 3.2.2 discussed how the constructivist perspective comprises a belief that new knowledge is socially and culturally produced through interactions among participants within a social context. Therefore, it is the task of the researcher to learn the methods by which their participants construct their respective realities and to make further interpretations about this knowledge by locating their meaning and action in large social structures (Higginbottom & Lauridsen, 2014).

Tailoring methods according to the participants’ background and ensuring they are culturally relevant is an effective strategy that enables participants to become invested in the research process and fully engaged in the study.

#### **3.3.1 Sample selection and Adequacy**

The sample selection was purposive, in which the sample selected was based on some features or parameters of the population (Silverman, 2014) for which “the processes being studied are most likely to occur” (Denzin & Lincoln, 1994, p. 202).

##### **Inclusion criteria**

1. Middle-aged Malaysians: men and women between 40 and 60 years of age;
2. English or Malay speaking;
3. Middle-aged adults who perceived themselves as being able to narrate their perspective on ageing.
4. Middle aged participants who are either healthy or have a chronic illness

##### **Exclusion criteria**

1. Malaysian who were not middle-aged (between 40 and 60);
2. People who were not fluent in spoken and written English or Malay;
3. Middle-aged adults with sensory/ cognitive impairments that having conversation in an interview impossible.

The study excluded persons with cognitive loss, such as dementia, and major hearing or sight loss. This exclusion is in place due to the researcher's lack of expertise in gathering information from such participants with 'special needs', particularly where there may have been difficulties in communicating the meanings successfully through language (see section 1.7). This might be a limitation in this study, as the study sample may not present large diversity. The participants were also not necessarily expected to adhere to other criteria such as education level, skills or traumatic events. These aspects were discounted, as they were not relevant to the study objectives. What the researcher aimed for at this stage was to understand the relationship between the event 'ageing successfully' among 'middle-aged adults', who comprised individuals from both genders and were from the three large 'ethnic' groups in Malaysia: 1) Malay, 2) Chinese and 3) Indians – with or without health issues.

In the current study, 28 interview sessions were conducted with 16 participants to reach the point of data saturation. Sampling adequacy is an important consideration in qualitative research. Bertaux (1981) argued that fifteen is the smallest acceptable sample size in qualitative studies. In contrast, Morse (2015a) mentioned that sample size does not matter but that the researcher's skill is important (e.g. Asking questions, sensitivity and experience, knowledge of theory and the literature, the ability to interpret data and to determine what these data contain that could be replicated (i.e. Data from several participants having common essential characteristics). However, Guest and Bunce (2006) stated that an appropriate size for GT studies would be approximately thirty participants. Meanwhile, Kuzel (1992) recommended the sampling of heterogeneity and research objectives, stating that six to eight interviews for a homogeneous sample and twelve to twenty data sources are needed to achieve maximum variation. Alternatively, Charmaz (2006) and Creswell (1998) contended that twenty to thirty participants and/or hours of observation might be required to reach saturation of the categories (Charmaz, 2006; Creswell, 1998; Guest et al., 2006).

However, the number of interviews would depend upon the analytical level which the researcher is seeking to achieve data saturation (Charmaz, 2014b), at which

point new data will not alter the categories or influence when theoretical adequacy is reached (Fusch & Ness, 2015; Guest et al., 2006). Given the values, beliefs, attitudes and life experiences, each participant's experience is unique and valid in qualitative approaches. Therefore, the number of participants required becomes evident as the research study progresses, until such time as the data reach saturation point and no new categories emerge (Charmaz, 2014b).

Constructivist Grounded theorists also have argued against generalisations that are stripped of time, place and the research situation, rather than opposing transferability per se (Charmaz, 2014a). This is mainly because the logic of generalising from non-probability samples is very different from that governing statistical generalisation (Maxwell, 1996). In addition, qualitative researchers describe their sample in great detail, which helps the researcher to decide whether or not to generalise a conclusion to similar cases observed by other researchers. It is notable that the criteria for making such decisions are more theoretical than statistical.

It also needs to be noted that a synthesis of qualitative research addresses an issue or topic rather than the effect of generalisability (Riese, Carlsen, & Glenton, 2014). Considering the nature of GT as a qualitative method of enquiry, external validity or generalizability can have limitations for the research being undertaken. This is because the ultimate aim of using CGT methodology is to identify the perspectives of a phenomenon that persist in a specific situation (Corbin & Strauss, 1990). Therefore, a study under grounded theory is reproducible in the limited sense that it is verifiable by way of finding new situations or other situations whose conditions exactly match those of the original study (Mjoset, 2005). An argument on this ground refers to sampling and the transferability of a finding to another community, as discussed in Section 3.5.

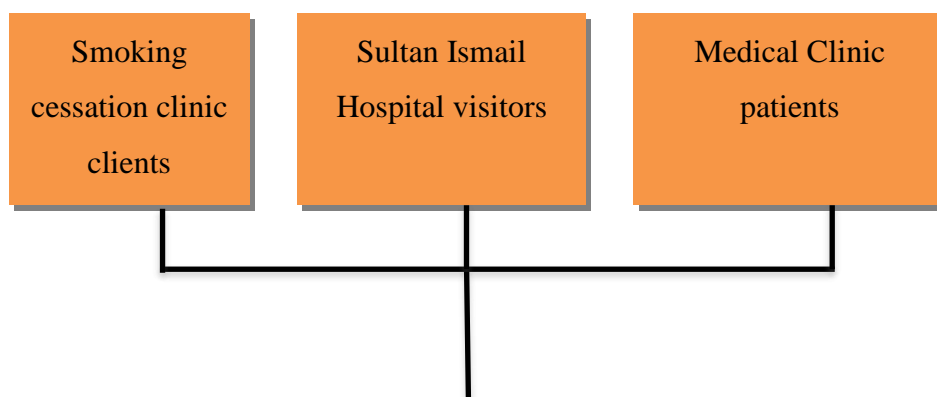
In view of the above argument, it is noted that the sampling strategy in GTM does not seek 'generalisation' or 'representativeness' and that the focus is on sampling adequacy rather than the size of the sample (Bowen, 2008). Similarly, this study is not aimed at the transferability of findings to a different population but rather to applying the theoretical understanding of ageing successfully.

### **3.3.2 Participant recruitment**

The research was conducted at the Sultan Ismail Hospital, Johor Bahru, Malaysia, which is the second largest hospital operating in the southern region of Malaysia (see Figure 3-4). The research participants recruited through Sultan Ismail Hospital (HSI) for reasons provided below:

1. This public hospital was chosen as a recruitment venue for participants as it provides service to nearby community with different backgrounds and status. Having a modern facility, it has been fully equipped to serve the community with all levels of care since 2007. The community in this area comprises a mixture of people who have a wide range of different cultural backgrounds, ethnicities, socio-economic statuses and educational levels. The nature of the hospital's setting has made it become a centre for people from different beliefs, cultures and religions and includes healthy and unhealthy people.
2. HSI has strong engagement with community. Aside from providing medical care, the hospital also engages in community-based activities such as home visits, outreach and health promotion programmes for patients and their families. It also provides curative and preventive care for the public, delivered by a multidisciplinary team. This team consists of consultants, physicians, matrons, nurses, social workers, health educators, nutritionists and other medical experts. They work proactively on its extramural activities along with community leaders. These community leaders are members of the 'Board of Visitors' who have dedicated themselves to the health and well-being of the patients and their families and who have been entrusted by the central government. This team also ensures that the hospital is working in partnership with the local community and private - and public-authority agencies to promote and deliver medical care. This hospital, therefore, is not only a venue for people with medical need but also healthy people.
3. HSI is a familiar setting to the researcher of the current study. I have worked for this hospital for four years as Head of the Health Promotion Unit. I also had the privilege of working for the community for a period of five years while

serving at the Johor State Department. I am therefore very familiar with the hospital operating system and the background of the community being researched in the study. Given these advantages and the access offered to a wide range of diverse communities consisting both healthy and sick people, the hospital is the best ‘one-stop’ setting for this study.



**MALAYSIAN MIDDLE-AGED ADULTS**

Gender	Malay	Indian	Chinese	Others (Seranian)	Total
Women	5	1	1	1	8
Men	5	2	1	Nil	8
Total	10	3	2	1	16

**Figure 3-4: Recruitment of participants**

The head matron from Hospital Sultan Ismail (HSI) appointed a staff nurse working in a ‘health clinic’, HSI as a gatekeeper in the research participant recruitment process. This health clinic is an integral part of medical and social activity in the hospital. It offers wellness programmes for the hospital community, epidemiological work and a smoking cessation clinic for patients who are interested in stopping smoking for various reasons. I was part of this smoking cessation programme, conducting protocol for behaviour modification, prior to coming to Edinburgh to do my PhD.

A number of meetings (see Appendix 7) were held between the designated staff nurse and myself to discuss the details of the recruitment procedure. Following these meetings, a recruitment list was generated comprising participants who had been identified from the 'Smoking Cessation Clinic' database of Sultan Ismail Hospital between 2011 and 2014. Recruiting a sample from a hospital setting, I was concerned over a bias of potential health focus versus taking individuals from non-medical premises such as a cinema. Several precautions were taken, such as having an interview venue close to the administration office but away from the clinics (see Appendix 20) and patients and by having the interviews commence with casual talk and then develop into factors that make the participant happy and which were important to them. The later questions related to the participants' experiences of ageing.

Prior to the interview, the staff nurse (gatekeeper) made the initial contact with the participants and a communication note (see Appendices 8 and 9) was prepared to educate her on the actions required when talking with the participants. She communicated with the potential participants regarding the aim of the research and the study's recruitment criteria. She assured them that their privacy and emotional well-being would be safeguarded throughout the research process. The staff nurse also went through the information study sheet with them and asked whether they would like to participate in the study. The participants who decided to take part in the study were then allocated interview appointment slots (see Appendix 10).

There were some individuals who were approached but who decided not to take part due either to not being interested and/or not considering that they were ageing successfully. Despite my best efforts to explain the nature of my study to the potential participants, some of the participants refused to take part for the reason that they were unsure whether or not they were ageing successfully, or otherwise they did not foresee the future. The term successful ageing was translated into '*keusiaan yang sempurna*' for local understanding. The word 'keusiaan' means ageing, 'yang' is conjunction that connects both words and '*sempurna*' could be translated as 'completeness'; it was therefore the closest translation for 'ageing successful' for a local understanding

among Malaysians. However, the word '*sempurna*' is highly subjective, personalised and varied according to individuals.

The participants also had the option of being interviewed at either their home or the hospital, as per their preference. During the follow-up calls and as the actual recruitment took place, both the staff nurse and myself thanked the potential participants for their interest in the research. On the day of the interview, I introduced myself and escorted them to the allocated data collection location.

I was permitted to use a room in the Clinical Research Centre located within the Sultan Ismail Hospital to conduct the interviews at the scheduled appointment times. In most cases, the participants were asked to come to the 'health clinic' at the front of the hospital's main entrance. I then greeted them and took them to the interview room.

The interview location radiated a relaxed mood that was beneficial in enabling an easy start to each interview. After conducting a few interviews, I realised that the interview location is of absolute importance for any qualitative interview. It can help the interviewee feel secure and not worried that his or her conversation is being heard by anyone other than the interviewer. Such an appropriate location also allows participants to be more open to discussing their problems and any difficult feelings they are encountering, all within a safe and confidential environment. Thus, a comfortable interview venue and convivial environment would lead to a more trustworthy conversation. I recall Kamaruzaman mentioning that he would prefer to be interviewed at the same location, which was at the hospital and not at his place of residence, since he did not wish his family to listen to our conversation.

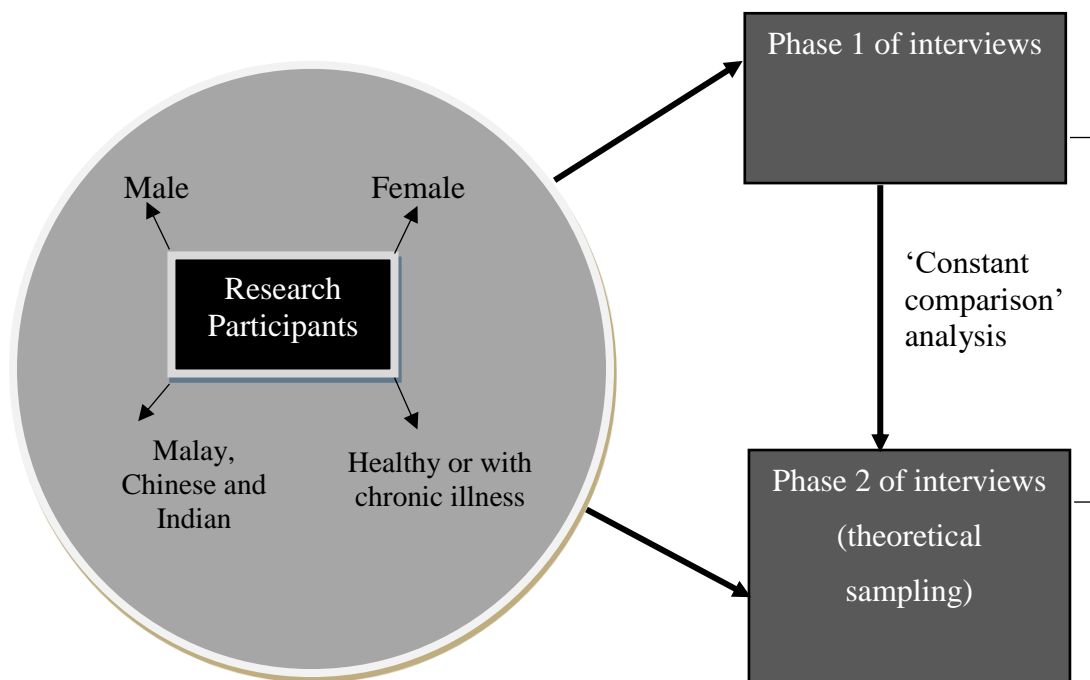
By conducting the interviews in a hospital environment, I expected the participants to discuss their ageing experiences in relation to health issues. However, this was not the case in this study since family relationships became the key aspect of discussion.

### **3.3.3 Research phases and sample**

The following section outlines the data collection and how it was conducted with the participants. The data collection was carried out during two phases of interviews with each participant (see Figure 3-5).

Middle aged adults who are healthy or with a chronic illness were recruited so that the current study sample would represent the general population and phenomena. A list was developed of existing patients who have chronic illnesses but at the same time showed continuous health improvements (e.g. Quitting smoking) was developed (see Appendix 27 and Table 3-2). In addition, healthy individuals were chosen from visitors to the Health Centre who met the criteria for inclusion in the study. The potential participants were recruited based on the recruitment list, and four of those who took part in the study were actually known to the researcher. These participants had participated in the behavioural therapy sessions at the Quit Smoking clinic between 2011 and 2013 at the time when I was delivering the behavioural therapy programme. However, at the interview sessions, I only recognised one of them and the others reminded me. This coincidence did not affect the interview process and I viewed it as a strength since I was able to establish a rapport with them spontaneously.

In Phase 1, data collection with the participants was conducted by interview. These interviews focused on exploring the participants' perception of ageing and successful ageing. The Phase 2 of interviews was by interview augmented by activities that were developed through theoretical sampling aimed at collecting further input and feedback from the participants after the initial analysis and coding (discussed in Section 3.4.2). The overview of the research phases is outlined in Figure 3.5 below.



**Figure 3-5: Overview of the recruitment of participants and data collection**

The ‘constant comparison’ was influenced by the Grounded Theory Method, which has been employed in this study for every stages of data collection and analysis.

The current study sample comprised 16 Malaysian middle-aged adults who lived in an industrial area, were aged between 40 and 60 years (Mean = 51 years) and contained a mixture of population characteristics: healthy individuals and individuals with chronic illnesses; and married and single adults. The heterogeneity of the sample of participants related to their:

- Gender (an equal number of Malaysian middle-aged males and females were recruited in this study).
- Health status (56% were individuals suffering from one or more life-threatening diseases, and 44% were healthy people).
- Ethnicity including Malays (63%), Chinese (13%), Indians (18%) and others (6%) (see Table 3-1).

All were from the metropolitan area of Johor Bahru District, which is in the southern tip of Peninsular Malaysia. Most of them earned a middle-class income and had similar

occupational backgrounds (e.g. Blue-collar workers: technicians, supervisors, clerks), meanwhile 25% were workers in administrative settings. Approximately 50% of the female participants were housewives. Their monthly incomes ranged from 0 to 6000 Malaysian ringgits (RM), which is equivalent to between 0 and 1000 pounds sterling (£), while the average monthly income was RM 2400 (£393). The participants' educational backgrounds were between six and fourteen years of schooling: 56.3% were secondary school leavers, 25% primary school and the rest had a higher education. The participants' characteristics are presented in Table 3-1 and the profiles of the research participants are given in Table 3-2 below:

**Table 3-1: The characteristics of the study sample**

<b>Characteristics</b>	<b>Percentage (n=16)</b>
<b><u>Ethnicity:</u></b>	
<i>Malay</i>	62.0
<i>Chinese</i>	12.5
<i>Indian</i>	19.2
<i>Seranian</i>	6.3
<b><u>Marital status</u></b>	
Unmarried/ Single	6.3
Married/partnered	81.3
Divorced/separated	12.5
<b><u>Education level:</u></b>	
Primary education	25.0
Secondary education	56.3
Higher education	18.8
<b><u>Classification of occupation:</u></b>	
White collar	25.0
Blue collar	31.3
Retired	12.5
Housewife	31.3
<b><u>Self-reported health status:</u></b>	
Healthy	44%
<b><u>Suffer chronic diseases:</u></b>	<b>56%</b>
Heart issues	44%
Diabetic	25%
Hypertension	44%
Asthma	6%
Renal failure	19%
<b><u>Self-reported health status</u></b>	
Very good	6.3
Good	62.5
Fair	31.3

<b>Self-reported functional ability</b>	
Independent	93.75
Partially dependent (self-helped but needed assistance from family members at times)	6.25
<b>Living with elderly/taking care of elderly</b>	<b>12.5</b>
<b>Living with children</b>	
No	18.75
Childless	25
Yes	56.25
<b>Age group of children: (In numbers)</b>	
0–18 years	8
19–25 years	15
26–30 years	11
31–35 years	4
36–40 years	5
41–46 years	1
<b>Self-reported current lifestyle:</b>	
Ex-smoker	25
Drinking alcohol (moderate)	12.5
Healthy diet	50
Exercise on 3 or more days per week	18.8
<b>Self-reported stress level:</b>	
Low	43.9
Moderate	31.3
Higher	25.1

**Table 3-2: Profile of the sixteen middle-aged research participants**

<b>Participant (pseudonym)</b>	<b>Age (years)</b>	<b>Gender</b>	<b>Race</b>	<b>Language spoken</b>	<b>Living with /taking care of older person</b>	<b>Health status</b>	<b>Marital status/ No Children</b>	<b>Lifestyle changes in the past six months identified from medical notes</b>
Analya	40	Female	Indian	Malay, English and Tamil	Yes	Healthy	Single	Healthy diet and manage stress well
Kamarulzaman	58	Male	Malay	Malay	No	High Blood Pressure and heart disease	Married	Quitted smoking and practice daily moderate exercise
Salleh	48	Male	Malay	Malay	No	Heart Disease	Married	Moderate Exercise and not smoking
Karim	60	Male	Malay	Malay	No	Heart Disease	Married	Not smoking and practice healthy diet
Selvam	53	Male	Indian	Malay and Tamil	No	Healthy	Widower	Not smoking, Very active and practice healthy diet
Maniam	51	Male	Indian	Malay and Tamil	Yes	Healthy	Married	Quitted smoking and do moderate exercise daily
Yusoff	49	Male	Malay	Malay	No	Heart Disease	Married	Not smoking and very active

Firdaus	49	Male	Malay	Malay	No	High Blood Pressure Heart Disease Diabetes	Married	Quitted smoking and do moderate exercise
Siti	57	Female	Malay	Malay	No	Healthy	Divorcee	Do moderate exercise and practice healthy diet
Shiela	44	Female	Others	Malay and English	No	High Blood Pressure Heart Disease	Married	Quitted smoking and practice moderate exercise
Yong	46	Male	Chinese	Malay, Chinese and English	No	Healthy	Married	Do moderate exercise
Kamsiah	51	Female	Malay	Malay	No	Healthy	Married	Very active
Noor Anis	58	Female	Malay	Malay	No	High blood Pressure Renal Failure	Married	Do moderate exercise and practice Healthy diet

Mei Ling	58	Female	Chinese	Malay and Chinese	No	High blood Pressure Renal Failure	Married	Practice healthy diet
Ayu	54	Female	Malay	Malay	No	High blood Pressure Diabetes Renal Failure	Married	Practice healthy diet
Khadtijah	48	Female	Malay	Malay	No	Healthy	Married	Do moderate exercise and practice healthy diet

### **3.3.4 Ethics consideration**

The School of Health in Social Science, University of Edinburgh, provided ethical approval. One issue identified was a potential distress to the participants during the interviews. In addition to the ethical approval from HSS, ethical approval was also obtained from the National Institute of Health (NIH) of the Ministry of Health (MOH) Malaysia. This latter approval is mandatory for conducting research, collecting study samples, carrying out interviews on its premises, and also for researchers such as myself who are employees of MOH. An ethics application was submitted through the National Medical Research Register (NMRR), a web-based service established by the NIH of the MOH, Malaysia. This web-based service provides guidelines for ethical applications and serves as the mediator and an approval for the Medical Research and Ethics Committee (MREC) and the Institute for Health Behaviour Research (IHBR) (see Appendices 3 and 4). The ethical approval was renewed in 2016 without changes to the sample recruitment (see Appendix 18).

Ethical approval (see Section 3.3.4 and Appendix 2) was thus obtained from both the University of Edinburgh and the ethical bodies in Malaysia. After the study had been granted approval from the ethical review boards (see Appendices 2, 3 and 4), an official permission letter, along with the ethical approval letter, was sent to the Johor State Health Director, requesting permission to conduct the research. A 'no objection' reply was subsequently received from the State Director (see Appendices 5 and 6). Several meetings (see Appendix 7) were held with the director, the head matron and other appointed research team members of the Sultan Ismail Hospital. These meetings were held to discuss the details of the study research and to request access to resources and support for data collection. Recruitment of the study samples commenced immediately following the granting of ethical approval.

Prior to commencing the interview with the participants, I explained my research to them and provided them with an information study sheet (see Appendices 11 and 12), which I went through with them to ensure they understood. Their anticipated risks, confidentiality and their rights as participants were also discussed. I reminded them that they had the option to withdraw from the study or end the interview at any time. The participants were given sufficient time to read through the information sheet and

reflect upon its contents prior to taking part and signing the informed consent form (see Appendices 13 and 14). Although most of the interviews were conducted at the hospital, one participant requested that her interview be carried out in her home.

In order to minimise any level of risk associated with conducting an interview at the participants' homes, the following precautionary measures were taken:

1. The Head of Health Promotion, Johor was informed of the visit
2. A list of emergency contacts was created and made available for me to use during the visit, if required. Although I had a lone working routine, the staff nurse appointed as gatekeeper kept a record of the interview schedule and was made aware of my movement.

To express my gratitude and acknowledgement for their participation in the study, a note of appreciation was passed to the research participants at the end of the interview. I outlined how their contribution was very meaningful and important to the study. In addition, a small monetary compensation of RM 20 (£4) was given to the participants to thank them for their time and also as a reimbursement for any transportation cost.

### **3.3.5 Confidentiality of data management**

To ensure the validity of the transcriptions and clarity in capturing every single word from the interviewees without any interruption or lapse of information, the interviews were digitally recorded.

All of the information obtained from the participants and the interview documents were kept confidential at all times. After each interview, the digital audio recording files and the observation field notes were stored in a locked cabinet at Sultan Ismail Hospital (HSI) during the period of data collection. During the post-data collection phase, these files and documents were transferred to a locked cabinet in the 'Post Graduate Research' (PGR) room, a working area at the SHSS, University of Edinburgh. The locked cabinets at both HSI and SHSS were allocated to the researcher and the keys were never shared with anyone else. In order to conform to the data safety requirements, the participants' responses and interview data were safely stored on a password-protected computer.

An explanation of the data collection and its management process was provided to the participants, stating that the recordings would be destroyed one year after completion of the study. The linguistic expert who was engaged for translating interview data signed an agreement to maintain the confidentiality of the data (see Appendix 28)

Throughout the study, the participants were given a unique identification so that they could not be identified from any documents (e.g. Transcriptions). A pseudonym (see Table 3-2) was used for each participant comprising a different name that is commonly used within the culture, to help the reader associate and feel the participants' narrations. The recorded audio files will be destroyed a year after completion of this study, which will be at the beginning of 2020.

### **3.4 Data collection**

Data collection in the current study used triangulation with use of multiple methods and data sources and use of an interview prompt sheet to collect data with a focus on the phenomena researched. Triangulation is a qualitative research strategy also to test the validity of the data collected through the convergence of information from different sources and data (Carter, Bryant-Lukosius, Alba). In the current study, the method of triangulation used involves the use of multiple methods of data collection about the same phenomenon.

Codes and conceptual categories emerge from the data collection stage of the area of enquiry as noted in Figure 3.2 (Strauss & Corbin, 1997a). These data have been collected from different sources using different methods (e.g. Documents, field notes, and interviews), thereby introducing a triangulation perspective to the data. The collection and analyses of the data occur concurrently and through the constant comparative method in this study based on the Grounded Theory Method (GTM). From the beginning to the end of the data analysis in this study, the element of constant comparison permits a systematic data comparison both within emerging categories and between concepts and categories, which is derived from the theoretical understanding (Baker, Wuest, & Stern, 1992; Charmaz et al., 2007; Charmaz, 2014a).

As Lauridsen and Higginbottom (2014b) mentioned, CGT permits an interactive stance between the emerging data, the participants and the researcher. This suggests

that the findings are interpretations of several realities, jointly constructed by the researcher and the researched (Wertz, 2011). Therefore, everything for the grounded theorist is data (Simmons, 2011). As a result, in the current study, a combination from a diverse range of data collection methods was used. These diverse methods comprised interviews with participants, mapping analysis, field notes, literature reviews, researcher observations and reflection.

Thus, the context underpinning ageing and successful ageing was co-constructed by the participants through an interactive process of interviewing, communication and action in practice by the researcher (Hesse-Biber & Leavy, 2008; Ong, 2012).

### **3.4.1 Phase 1 interviews**

In the Phase 1 data collection, the researcher of this study used interviews, observations and field notes to gather data from the research participants. The Phase 1 of face-to-face semi-structured interviews was conducted between April and June 2015. Each interview lasted for approximately 45 to 130 minutes. However, additional time was spent building rapport with the participants prior to the interview taking place.

The participants' personal data such as demographic data, family background and health status were obtained using a special form (see Appendices 15 and 16). Like the other forms, this form was also created in both English and Malay. This form was completed in around 15 to 20 minutes in most cases. In addition to questions on the participants' background, the data collected from the form discussed lifestyle patterns and how these had changed over the years, in addition to ascribing factors that had contributed to these changes.

A prompt sheet was developed in advance (see Appendix 17) to guide the interview. The following questions were developed, with question numbers 3, 4 and 5 linked to the model of TPB (see section 3.2.5.2):

1. Can you please tell me about the things that you have enjoyed most or are proud of?
2. How would you like to see yourself in five to ten years' time?

3. How do you intend to age successfully?
4. What are the aspects that motivate or become a barrier for you towards ageing successfully?
5. How do you see yourself associated with the risks of ageing?

Although a prompt sheet was created to probe the responses of the participants, I also allowed the interview to remain semi-structured. The research participants were given scope to define their perception of ageing and to be open as far as possible.

The participants were first asked about the activities that they most enjoyed doing or were proud of. The researcher then progressed to how they saw themselves ageing. The participants were also invited to discuss the age at which they would consider themselves as 'becoming old'. The interview questions were later explored around the perceived meanings of SA and how the participants constructed it in their daily lives.

These questions helped the researcher to explore the perceptions of later life and the attributes that were found as dominant aspects of SA. Additionally, I aimed to understand how the norms and culture of this population might influence their experiences and perceptions of ageing. For example, how the participants perceive the development of their later life and how it links to the norms, ideals and beliefs as the significant aspects within their culture (Gebauer, Sedikides, & Neberich, 2012; Sedikides, Gaertner, & Toguchi, 2003). The participants' own experiences of ageing and the major events to have taken place through the course of their lives, which had cultivated their ideas on ageing, were also explored.

Theoretical coding of the phase 1 interviews highlighted how the research participants in this study consistently aggregated stories around 'disruptive events' (DE) in the present and how these events affected their old age. These DE that they talked about created an uncertainty with regard to their future, which impacted on the fundamental probability of achieving SA in later life. Hence, the stories and experiences from the participants described how a typical behaviour of 'coping uncertainty' caused by DE was synthesised. I shifted the analysis to how people act, relate and respond to DE. I then tried to composite the descriptions on how these people manage or live in the best possible way in the presence of the 'uncertainty' that would influence their later life

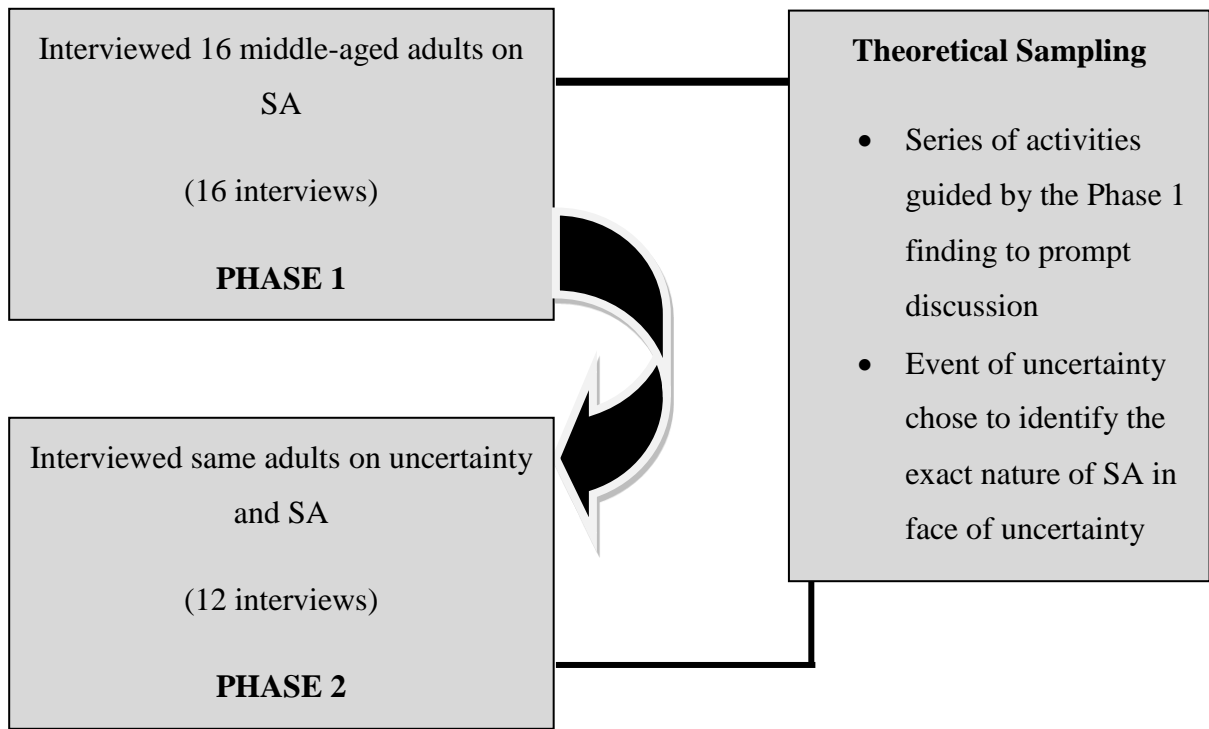
(Morse, 2015b). Most distinctly, when comprehending these stories from the various participants, I became aware of predominant behaviours and norms that have influenced the research participants to react to DE and manage ‘uncertainty’ to achieve SA in the future.

### **3.4.2 Phase 2 interviews: Theoretical sampling**

The data collection of the Phase 2 in this study was conducted with the same participants as in the Phase 1, and is guided by a theoretical sampling strategy. Theoretical sampling is referred to for further data collection, guided by the initial coding to enable additional data to be collected systematically to explore the emerging patterns and assist in forming a theory (Charmaz, 2014b; Charmaz & Bryant, 2007). The nature of theoretical sampling exerts a measure of pressure to check ideas against direct empirical realities in order for the study to have solid data and for sound ideas to be analysed (Charmaz, 2014b). In this present study, theoretical sampling reduces the challenges of exploratory study with identified overarching ideas that have narrowed the search into particular empirical work on uncertainty related to ageing and disruptive events in midlife. For this reason, theoretical sampling is the strength of GT, constituting a critical stance towards empirical data within GT usage (Goldkuhl & Cronholm, 2010). Extending to theoretical sampling helps the present researcher not only to gather additional data to fill the gap in identifying the conceptual model; it is also helpful for the purposes of triangulation and validation (see Section 3.5.6.3). In addition, through theoretical sampling, the study gains a deeper understanding of earlier statements made by the participants.

In this study theoretical sampling was conducted among the same participants who discuss further the dynamic of uncertainty and how they cope with ambiguity, which was emergent as an overarching theme in the initial Phase 1 analysis. The present study agrees that the theoretical sampling is derived “not just from people, but also from the settings and events” (Bryman, 2004a, p. 305) that lead to theoretical saturation, at which point the categories will have been completely explained and the relationships between them assessed (Amsteus, 2014). Additionally, since the successful conducting of theoretical sampling depends on having already identified the initial categories, earlier theoretical sampling may result in one or more of the common GT pitfalls.

These may include the premature closure of analytical categories, the title or redundant categories, an over-reliance on overt statements for elaborating and checking categories, and unfocused or unspecified categories (Charmaz, 2014a). In addition, the present study has been guarded from these potential problems through the use of a coding book and memoing that captured mobility within codes. The present study has benefitted from the researcher being open-minded with regard to what was said by the research participants and related information, thereby keeping the analysis of the study analytical.



**Figure 3-6: Flowchart on Theoretical Sampling**

Types of research participants	2015			2016		
	April	May	June	June	July	August
Middle-aged adults who is <b>healthy</b>	2	3	2	Nil	3	3
Malaysian middle-aged adults who is with <b>Chronic illness</b>	3	6	Nil	5	2	Nil
Malaysian middle-aged adults <b>Men</b>	4	3	1	2	3	Nil
Malaysian middle-aged adults <b>Women</b>	1	6	1	3	2	2



**Figure 3-7: Sequence of Theoretical Sampling**

The process of theoretical sampling allows for the emergence of concepts and determines what information will be sought next and from whom. Particular factors in relation to gender, health status and culture, religion, perception of ageing, understanding of disruptive events and factors influencing management of uncertainty were explored using theoretical sampling as shown above. The interview questions in this study were changed at the theoretical sampling stage due to an ongoing analysis that had narrowed down the focus of the study (Charmaz, 2014a). Using additional data from theoretical sampling, the categories were then further conceptualised into ‘theoretical constructs’ by establishing relationships between categories (Strauss & Corbin, 1997a). This is the major difference between GT and other qualitative research methods since the aim of the approach is to generate a theoretical understanding.

Further data were acquired using theoretical sampling until the existing categories were 'saturated' (see Section 3.3.1).

At this phase of interviews (developed during theoretical sampling), three activities were conducted to contribute to more data collection on the findings that had emerged from the Phase 1 data collection and analysis. The Phase 2 interviews were augmented with a series of activities guided by the initial findings, to prompt discussion. These activities consisted of: (1) cards containing factors that contributed to the sense of 'becoming old' arranged according to priority, (2) the creation of timescales for the properties of successful ageing and (3) responding to a vignette. These activities were based on emergent theory identified from the Phase 1 findings and were found to be advantageous to open-ended exploration by enabling the participants to focus on the discussion that helped underline the phenomenon being studied.

The three activities conducted with each participant in the Phase 2 interviews, aimed to facilitate further understanding of how individuals cope successfully with uncertainty in ageing successfully. During these interviews I asked the participants 'how do you cope with uncertainty to extend well-being in later life?' to further understand issues around how people react to uncertainty. The activities conducted during the Phase 2 interviews were discussions with the participant throughout the activities (see Section 3.4.2) in order to understand the practices that they engaged in to help them cope with DE and uncertainty.

The activities highlighted below were piloted with four individuals from a similar background prior to being carried out with the actual participants. After the pilot sessions, the language and the instructions for the activities, as well as the order in which they took place, were slightly modified to keep them simple. For example, the word 'autonomy' was reworded to 'freedom to make own choices/decisions/opinions' as this had not seemed to be clear to the participants in the pilot sessions. The instructions for the activities were changed to step-by-step directions and were also modified to include a clear explanation of the actions that needed to be carried out. The modifications from the pilot sessions helped the participants to better understand the flow of the activities, meaning they were able to respond better to the questions

and/or what was expected of them. The interviews in Phase 2 were also taped and the data were translated and transcribed before analysis.

### **Activity 1- 'becoming old'**

In the first activity, the participants were asked to arrange cards containing the crux of the discussions about the factors that contributed to the sense of 'becoming old' (see Appendices 19 and 21), from the most influential to the least influential factor. These factors were based on the initial categories that were identified from the Phase 1 interviews.

### **Activity 2- priorities in SA**

The participants were required to categorise the properties they perceived as successful ageing against three-time frames – short-term, medium-term and long-term, - that would fit according to their priorities (see Appendices 19 and 22). The participants were then asked to discuss their actions with regard to why they placed some of their actions for successful ageing within a particular timescale.

### **Activity 3 – coping with uncertainty**

In the last activity, two vignettes were prepared – one for the healthy participants and the other for those with chronic ill health – for the participants to respond and discuss how they would cope with the identified uncertainty (see Appendices 19 and 23). The vignettes contained short responses that were taken from the viewpoints of some of the participants from the previous interviews and after the initial coding. Drawing upon these viewpoints, I asked the participants what the vignettes meant to them.

#### **Vignette 1 (for the healthy participants)**

*“I can do my daily chores without the help of others now, but in the future my body might let me down. I am single now, so if I get sick, there would be no one to take care of me. This leads to an uncertainty for the future; in the present days, therefore, I am engaging in activities that may give some assurance to my later life.”*

## **Vignette 2 (for the participants with chronic illnesses)**

*“I can do my daily chores without the help of others now, but in the future my body might let me down. I am suffering from three chronic diseases including heart issue, which might be controlled, but they cannot be cured. Even though I have undergone bypass, my heart may collapse at some point. This leads to uncertainty for the future; in present days therefore, I am engaging in activities that may give some assurance to my later life. Thinking that now I have come to my awareness. My diet needs to be healthier. Maybe engage in spiritual activities more than before at old age. Our death is unpredictable. But, if blessed with a long life, normally that’s what people do when they become older. I also want improve my relationships with the people who are important to me.”*

After listening to the vignette, the participants discussed the questions below:

1. What is your perception of the vignette above?
2. How do you connect the events of ‘uncertainty’ and ‘certainty’ in your present life to help shape your expectation on future ageing experiences?
3. How do you cope with uncertain incidents in your life to create assurance or certainty for your later life?

These activities significantly helped in getting the participants explicitly focused on the issues that the researcher wanted them to focus on about how they tended to cope with the uncertainty identified from the initial data collection.

### **3.4.3 Affirmative actions and dilemmas during data collection**

During the interview sessions, I tried to encourage the participants to continue their narrative by making affirmative actions using expressions such as “*Yes, I understand; okay; hmm; Uh-huh; so, tell me more about it*”. In addition, I nodded my head as a gesture to confirm that I understood what they were saying.

As the interviews proceeded, I experienced how the building of rapport with some of the participants was a continual process. Some of the participants felt uncomfortable to start a conversation, while with others it took a while to get beyond their defensive stance and get them into a comfortable feeling during the interview. In contrast, other

participants were able to settle down quite comfortably before the interview began. For example, Karim, while responding to the background and health status form, also began discussing other issues without me actually having to ask him.

Nevertheless, throughout every interview, I sought to address the feeling of discomfort in each participant. For example, the first participant, Analya, was anxious that her responses might not meet the research expectation.

*Analya: "...both health and relationship have the power to change our future. Do you think that I'm right?"*

Therefore, I had to reassure her repeatedly that the whole point of this research was to understand how she made meanings out of her experiences; thus, nothing was considered to be wrong or right.

*Researcher: "Well, it is not about what is right or wrong; I would only like to know your understanding on the subject."*

*Analya: "Well, do you think that I understand your questions or my responses were deviated from your questions?"*

*Researcher: "I should say you are really doing well, so don't worry about getting it right, I'm happy to hear your experiences and expectations in your own words."*

I encountered many other similar responses. Another example from the second interviewee is as follows:

*Kamaruzaman: "... anyway, I knew that this was just the start, you may have many questions that ought to pry into emotions....I hope that I do not cry (laughed)."*

*Researcher: "Hmm... I can promise that we are only going to have a friendly chat; my intention is to understand better your expectations and feelings about going into older age. We can stop at any time if you are feeling distressed about continuing further."*

Soon, I realised that my relationship with the participants had started evolving promisingly and pragmatically. I picked up with the participants after almost a year away with a phone call and explained the need for the second interview with some activities. It was considerably easy to gain the support of most of the participants since

it had been communicated in the initial interview that a later session would be possible and they might be called again. A greeting card was posted to each participant a week after the final interview session as a gesture of appreciation and to inform him or her that the data collection had now come to an end.

The potential for any discomfort and/or insecurity that the participants might have been feeling was addressed from the beginning of the recruitment. However, even hailing from the same heritage, I felt disturbed when some of the male participants broke down emotionally and began crying during our interview sessions. I could also sense the extent of the discomfort from these male participants towards myself.

As in most other Asian countries, the social structure in Malaysia is strongly focused on a patriarchal heritage that emphasises male pride. From a young age, males are raised to retain control of their emotions, and if they do show emotional turbulence in public, it can only be seen as sporadic. It would therefore be seen as a sign of weakness if they were to cry in the presence of a female counterpart. The act of crying is normally accepted and expected for women in the society, but the same is not true for men.

Although I have encountered similar situations with men crying in front of me when I managed health education programmes and provided counselling for end-of-life patients and their family members, dealing with this as a researcher was still a whole new experience and was a delicate situation for me to contend with. This was because I had to calm the participants who felt stressed in the interview session at the same time as engaging them in a fruitful discussion.

This situation was addressed as part of the ethical review at the level of the University of Edinburgh's School of Health in Social Science Research Ethics Committee. I was required by my supervisors to outline how I would address the issue of vulnerable participants. Given how there was the potential for the participants to become emotionally distressed during the interview, the Research Ethics Committee instructed that a plan for handling such a situation be given attention prior to the data collection activity. The ethics panel raised relevant points as to what the researcher would do during such circumstances if the participants felt upset or embarrassed. In parallel to this, I created a debrief form containing information on where the participants could

go to seek help if they continued to experience emotional distress following the interview. The debrief form was supported by a multilingual (Malay, English, Tamil and Chinese) pamphlet on positive mental health which included suggestions on how to manage stressful moments. This pamphlet was published by the Health Promotion Department, MOH Malaysia (see Appendix 30).

While the intention was to have a stress-free interview, this was not the case for some of the participants, who ended up in tears and with brittle voices on many occasions. Most of the participants talked about the 'limited amount of time' they had for their future. Their desire was to make the current moment memorable with their loved ones. The participants became emotional especially when talking about matters that were related to their relationships, the attachment they felt to others, their failures, an uncertain future and how their experiences had shaped them into the people they now were. I noticed how the participants would experience flashbacks to old memories when they connected the future with the consequences of their past decisions. At times when the participants were feeling distressed, I gave them enough time to calm down without interrupting them with further interview questions. For example, one participant began the interview enthusiastically; however, his voice changed and became brittle towards the end of the interview and he could not hold his tears when he began talking about his role as a parent. He cried while talking about his failure to continue the legacy of his late parents.

*"I failed to bring in that legacy, I'm old now (paused, voice lowered)...(cried)... Oh... It's so easy for me to break into tears"-  
Kamaruzaman*

I handed him a box of tissues and carefully said to him that it was completely natural to cry and that it was acceptable for men to do so.

One of the most difficult interviews I experienced was with a male participant (Firdaus). Firdaus was suffering with triple diseases: unstable angina, diabetes and hypertension. He appeared to be both jovial and someone who had so much interest in living his life, and he appeared to have a good relationship with his family. However, as the interview progressed, I could see that he continued to be significantly haunted by his perceived past mistakes in life. At the end of the interview, he asked if I could

help to examine his mistakes, as he said he had been looking for an ‘appropriate’ person to discuss them with for a long time, and he felt I would be the right person. He then revealed the dark side of his past and that he was deliberately not undergoing surgery to repair his narrowed heart vessel as a form of self-punishment for his wrongdoing. He also believed that he would not survive the operation, and tears were rolling down from his cheeks as he conveyed this information. It was extremely difficult and pressured to be in such a situation in which I felt my opinions could influence his decision to undergo surgery. I therefore had to put the message across correctly; especially given that what I was about to say could potentially save his life:

*Researcher: “Looks like we have come to the end, do you want to tell me anything?...that I should know pertaining to this study that I missed out?”*

*Firdaus:(laughed), “I had been asking many people about their opinion on a matter and have only received negative responses so far. But, today looks like I have found the right person to put it across...since we have discussed about the whole journey of my life.”*

*Researcher: “Yes”*

*Firdaus:”Do you think what I am going through at this stage is right? Having this illness, the way I educated my children. My past problems, were they correctly done?”*

*(Perceptible silence and then he cried)*

*(We kept silent for a while)*

*Researcher: “Let me tell you my opinion sincerely.”*

*Firdaus: “Yes, don’t hide.”*

*Researcher: “Yes, let us put this in a good term. As you know, I am not someone in your circle of friends; we only met once or twice before this interview when I consulted you to quit smoking sometime two years ago. So, it means that I never had a specific perception about you. Ahh...I believe that our action in a particular time is derived from our thought. Sometimes, our thoughts might be obscured by other issues. However, what we decide at that moment is definitely the matter of interest to us and the people we care for. The decision we took at that moment might be weighed as the ‘right’ decision. But, we won’t know if the decision would still be ‘right’ in*

*the future. The future is not predictable, as you mentioned; the decision we took might turn out ugly as time passes, even though it was weighed as the 'right' decision at the time it was made."*

*Firdaus: "Yes, exactly... 'right' at that time."*

*Researcher: "Yes, after a year passes by, two years or in five years' time down the road when we might look back and think why we decided so? Of those on whom the decision that impacted the present moment, laying the blame on us or making it a penance won't heal what has been destroyed. Facing it and moving on would be the best."*

*Firdaus: "Yes, no one is perfect"*

I felt overwhelmed with his information and his voice continued to echo in my mind afterwards. I strongly felt that he needed more help. Although I felt hesitant in providing him opinions based on my personal experience, it was essential to make him feel comfortable and also create a sense of trust and confidence towards me. Since Firdaus confessed that he had already delayed his surgery twice out of a fear it would fail, I decided to reveal this decision not to undergo surgery to his doctor, who may wish to arrange further counselling sessions for him. Although I felt the decision of talking with his doctor could be controversial in terms of ethical issues, it was important to address his grief and severe medical illness. I called Firdaus the next day, informed him of my intention, and obtained his permission to do so. The doctor referred to Firdaus's case has been notified that the researcher knew the situation because of doing the research (see Appendix 26). Later, at the second interview for theoretical sampling, Firdaus mentioned that he had yet to undergo the surgery and was currently taking traditional complementary medicine, but that bypass surgery was planned for two months' time.

The above-mentioned experience points to an event encountered by researcher Kaiser (2009), who conducted a study with breast cancer survivors, in which she had an ethical dilemma with one of the participants who was marked with financial struggles but refused to attend to a breast cancer support group as she was a lesbian. This information from the participant presented an ethical dilemma for Kaiser as to, whether or not to share the participant's insights with a medical professional. In her paper,

Kaiser mentioned that, by doing so, the medical professional might change behaviour towards the participants, but it would still benefit her. However, Kaiser decided not to share the information with the relevant authority on the grounds of confidentiality, but reported it is a limitation of the dominant approach. However, in health research, speaking with respondents about how data will be shared with medical professionals is especially important. This arises both in this study and that of Kaiser highlighting the importance of modifying the informed consent process and allowing participants to make informed choices about the use of their information (Kaiser, 2009).

My past work experience with public engagement thus collided with the present in terms of it appealing to this participant's sense of confidence. The participants were reminded that the purpose of the research was genuine and that it was not being used as an opportunity to delve into the participant's personal matters. I was perceived by the participants as being flexible to talk to about personal topics, and for sharing some interests and background with some of my participants during the interviews. Some of the participants also sought my advice on health-related issues and the side effects of their medication, and they carried out some crosschecking about their behaviour. Although I felt hesitant in advising them based on my professional and personal experiences, it became obvious that this rapport was important to the participants and for them to be involved in a concrete conversation. Without this gesture, I believe I may not have seen the participants for a second interview. A similar situation was handled by a feminist researcher, Guimaraes (2007), in a study conducted on the police and women who were reporting abuse in a women's police station in Brazil. The data collection focused on how the police officers communicated with the women at the time the reports were filed. Although, Guimaraes began with a commitment to function 'objectively' in her data collection, she eventually felt she had a moral responsibility to intervene in a situation if it helped the women involved in the study, such as by giving advice about what should be in the police report. Since the entire communication during the report taking was recorded and used as the 'data' for the study, it became an important ethical consideration. However, the study researcher, Guimaraes (2007), reflected that her involvement brought insight to the phenomenon researched by revealing some blind spots.

## 3.5 Data analysis

### 3.5.1 Transcription and translation

The interviews were later transcribed verbatim. It took between seven and nine hours to transcribe one hour of an interview session, with a further one to two hours needed to check the transcription against the audio recording. In total, 35 hours and 35 minutes of interviews in this study resulted in roughly 295 hours transcription.

All interviews were conducted in Malay and only adults who could converse in either Malay language or English have been recruited to participate in the study. The transcriptions were translated from the Malay language to English for both Phase 1 and Phase 2 interviews. The translation involved the use of forward and back translation to check if the interview narrations matched with the original meanings for a few randomly selected interview transcriptions. Forward translation is the process of translating data from the source language to the target language, and back translation is the process of translating back from the target language to the source language (Nurjannah et al., 2014). Forward and back translations were carried out to ensure that the translations contained words that closely resembled the participants' own words and meanings. The process was continued until such time as the translation was satisfactory. The process of understanding is implicit in every translation. The interview data were transcribed and translated by myself prior to the transcriptions being sent to a linguist for proofreading, and we subsequently had a discussion to establish that the terms used agreed in both languages. For example, the word 'we' (*kita*) is used to refer to 'I' (*saya*) in local expressions; therefore, the context in which these words were used needed to be carefully observed in terms of whether the participants were discussing an individual or collective point of view. It was time-consuming and tedious work, but the process did enable me to get a better feel and good grasp of the data. Although the interviews were translated from the Malay language into English, the data analysis was conducted in English in order to adhere strictly to the Grounded Theory methodology of using gerunds in coding (Charmaz, 2006).

The data analysis was conducted using NVivo 10. Given the volume of data, this software helped to analyse the data systematically with limited time. I was able to work

around different data types (e.g. Documents and folders) and support different dimensions of coding.

### **3.5.2 Treatment of literature in Grounded Theory data analysis**

There are conflicting among qualitative researchers on referring to literature reviews at the onset of a study in relation to how the use of literature can enhance rather than constrain theory development (Chen & Boore, 2009)

Some researchers oppose the conducting of a literature review in the substantive area under study due to the potential contamination or impediment the researcher's analysis of the codes emerging from the data (Glaser, 1992, Stern 1980, Lincoln & Guba, 1985). This is because the literature is able to 'provide examples of similar phenomenon that can stimulate' the researcher's thinking about 'properties or dimensions' that the researcher can use literature to be more sensitive in analysing the data (Strauss & Corbin,1998; p45). However, Chen & Boore (2009) highlighted that reviewing literature that focuses on the area being studied may bring some 'conceptual clarity' (p 2253).

In contrast to traditional grounded theorists (see Section 3.2.3), constructivist researchers immerse and position themselves within the study as the creators and re-creators of the social process. As mentioned by Charmaz (2014a), CGT in practice cannot be linear in form but must be multidirectional. It also cannot be detached from the literature or from the researcher's involvement, and the results of the theory are interplayed between the researcher and the participants (Age, 2011; Charmaz, 2014a).

According to Charmaz (2014a), the ability to have a range of ideas about the phenomenon under study (successful ageing) constructed through observation, interactions and materials gathered in settings and cultures that are different from those in the literature review is definitely an advantage as opposed to a shortcoming. For example, in a study by Featherstone and Wernick (1995), the older people from an Asian background were considered to have attained a state of "grace and were nearer to God and eternity" (p.56). Kathi Miner-Rubino (2004) mentioned that people who could not meet societal expectations such as those going down "the economic 'ladder' may feel less powerful, less confident and have a weaker sense of self" (p.1608). In

Malaysia, social status based on achievements by individuals and their family members is also an important form of social mobility.

One example of the importance of being immersed in social processes as a researcher concerns the religious practices of people living in Malaysia. From my personal experience, I understand that it is common for middle-aged Muslims in Malaysia to express the need for Haj, which is the Islamic pilgrimage to Mecca taken at least once either before or during Muslims' later life. The country's Hindus and Buddhists, meanwhile, believe in karma and rebirth. They talk about the theories of karma and how these are connected to a person's or group's misfortunes, and they often like to share stories of karma's effect in life with their friends and families. In addition, pilgrimages in late life are also perceived as an important element of ageing for many Hindus and Buddhists. Muslims believe that they are held responsible for their children's behaviour and that they are bound to carry the 'negative' or 'positive' consequences of their children's actions with them when they die. However, since Malaysia comprises three major ethnic groups, the Malay, Chinese and Indian races, the ageing population is attributed to the diverse and assimilated culture underpinning their ageing process.

These views provided me with some ideas for probing with open questions when conducting enquiries with the participants in my study about the meaning that drives their actions in relation to ageing successfully (Sbaraini et al., 2011). By studying these empirical events I pursued the research questions and developed analytical themes about them through empirical data collection (Charmaz, 1990). Substantially, the early idea for the research came from sources other than data as recommended by Charmaz (2014). In GT, this area of enquiry is called the 'substantive area' (Urquhart, Lehmann, & Myers, 2010).

Glaser and Strauss also mentioned that the researcher does not enter into the research area without an idea (Heath & Cowley, 2004), however, qualitative research relies on those who conduct it (Bryman, 2004b). Nevertheless, CGT allows for the inclusion of the researcher's experience in the theoretical analysis and also for the informing of concepts to define and develop ideas around the data collected. During my 13 years of working with Malaysian communities as a health educator, I have witnessed the

behaviour of middle-aged adults in the medical and primary care settings. In addition, from the time spent with my older parents, I might have also unconsciously observed their behaviours during their own ageing process. Furthermore, I am now in my early 40s and have started to reflect on my own current life and started to form perceptions of later life. These different experiences have been a useful foundation for the present study's data collection and analysis.

For this study, the literature review and insights of the present issue by the researcher do not influence the data collection or the analysis process but rather compliment them by increasing the depth and relevance of the substantial area under study. The key aim prior to entering the field of investigation was to explore the conceptualisation of successful ageing. Following the Phase 1 data analysis, uncertainty and its management emerged as important aspects concerned with ageing successfully. Thus, the subsequent data collection in Phase 2 changed its focus toward the pertinent issue that emerged – uncertainty and successful ageing.

### **3.5.3 Constant comparison**

Through a constant comparative method of analysis, I made 'constant comparisons' inductively (with an open mind without pre-categorisation), influenced by the CGT (Chenitz & Swanson, 1986). As a result, I gathered and analysed data simultaneously from the time of the interview with the first participant (Analya). For example, I compared data from Analya's values for ageing and her intentions and barriers to age successfully. In her interview, Analya portrayed a strong expectation for family relationship and presenting resilience and spiritual guidance in accordance with good ageing. However, at the same time she also worried about the future insecurity associated with being single (see Chapter 4, Section 4.2.2) and discussed her efforts to cope with the ambiguity she sensed Ayu also highlighted that she wanted her children to get married and have their own family to avoid them being in a situation similar to herself, whereby she is dependent on relatives.

The second participant, Kamaruzaman, had talked extensively about the impact of his ill health in his old age, resulting in him having limited time to complete his actions. Again, I compared the value he perceived with regard to ageing with his intentions and

barriers towards ageing successfully. At this point, I went a step further as I compared the values of ageing that were observed between Analya and Kamaruzaman. It was evident that both of these participants were talking about certain events that were disruptive and challenging to their desired ageing. This iterative process of the analysis progressed up to the last participants. I moved back and forth between the analyses and emerging data to make the collected data progressively more focused and the analysis more theoretical (Charmaz & Bryant, 2007; Hoflund, 2013). I realised the focus of the data collection had steadily moved towards how the participants reconstructed the ‘self’ to manage the uncertainty involved in sustaining or increasing their well-being in the future. In addition, my understanding of Malaysian culture helped me to understand the participants’ specific values given to the collective elements of family achievements and details of spiritual attainment as part of good ageing.

Through the constant comparison and initial coding (see Sections 3.5.3 and 3.5.4), the data transformed into how the participants reconstructed themselves to cope with uncertainty to age successfully. However, the uncertainty felt by the participants in relation to ageing successfully that is posed by certain disruptive events (e.g. Ill health and family issues) seemed to be an issue for them in achieving their desired old age (see Chapter 4, Section 4.4). Therefore, the epistemology of this study was shaped to uncover the ambiguity sensed towards the future and how the participants coped with it and sought to improve their well-being in the future.

#### **3.5.4 Coding**

Coding is another important aspect in data analysis, whereby data coded with substantive categories to reflect the properties of what the participant said or the observed events, actions or other dimensions of the phenomena.

## Initial coding

Coding begins from the first interview and continues through the subsequent interviews. The outcome of result from initial coding is the progress of descriptive codes from early data collected.

The data collected from all 16 participants was subject to initial fragmenting through initial coding to explore possible information and evidence of the actual phenomena being studied. Key phrases in the research participants own words are coded line by line in vivo coding to identify concepts and key themes. The process resulted in open codes. Later the code phrases were reduced by grouping similar code phrases together. Below are examples of line by line initial coding:

Line by line coding	Data collected
Making family attachment Depending on children	For a better ageing I need to <u>be good to my children</u> so when <u>I have health issues they'll look after me</u> (Noor Anis).
Rationalising future security Looking for emotional support	When seeing those in between 38 years and 40 years old, <u>I got scared</u> . The question of <u>who is going to look after them in the future</u> ...? I strongly feel every woman should <u>get married and have their own family</u> . At least they will have a partner who can <u>support them</u> (Analva).

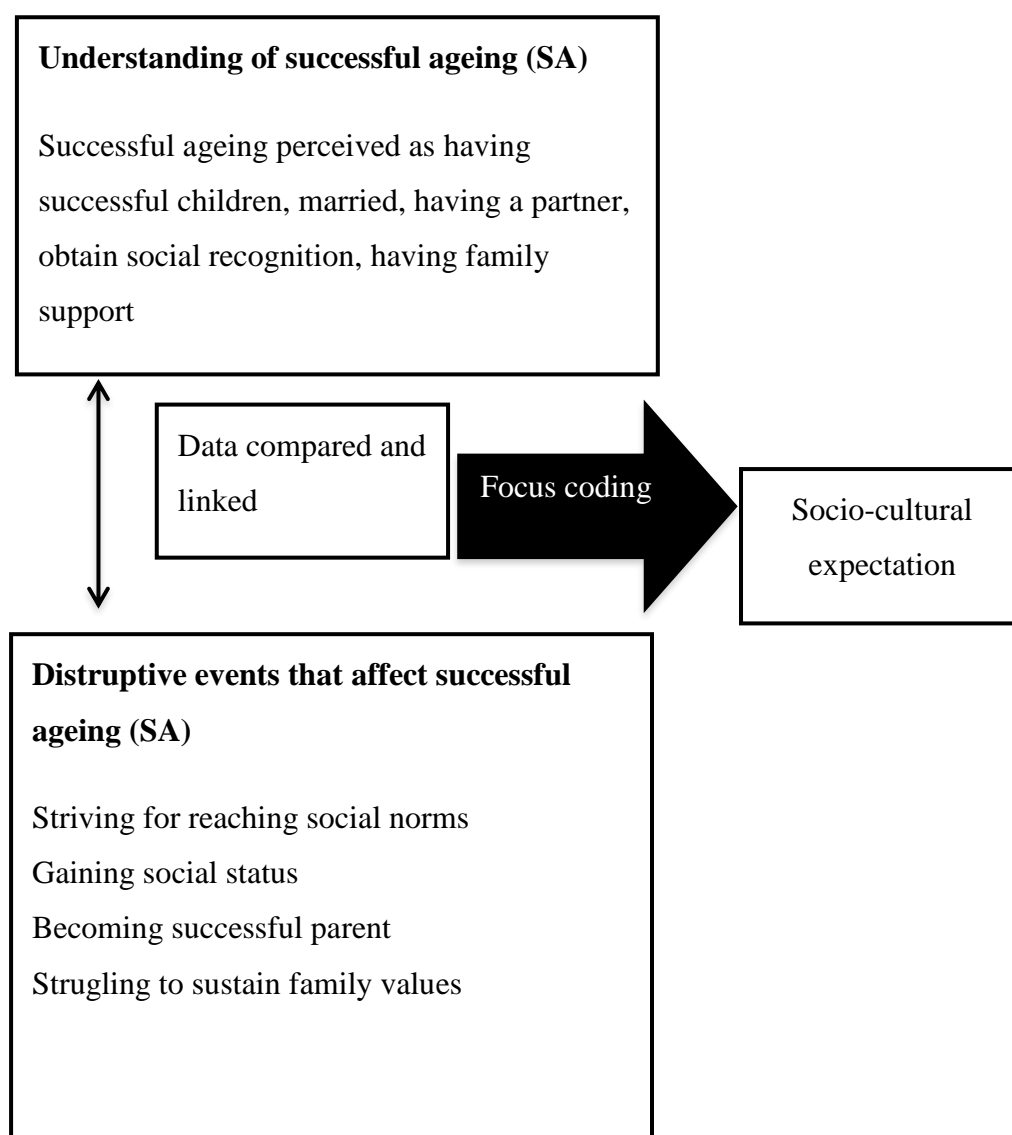
**Table 3-3: Proseses of initial coding**

## Focus coding

The initial codes subsequently shifted to focused coding with precise descriptions (Kathleen Charmaz & Bryant, 2007). The focused codes were then compared to identify the similarities and differences between them. Similar codes were clustered

and given labels, which were then used as a guide to the categories (see Appendix 24). One of the core categories on disruptive events that affects successful ageing that resulted from focus coding in this present study is socio-cultural expectation (see Figure 3-8).

In Figure 3-7, an example shown of a focus coding on how a number of codes from data were compared and linked about perception of successful ageing with codes about how disruptive events affects it. This outcome was linking a number of codes about understanding of successful ageing that emerged to uncertainty that affects successful ageing in the presence of disruptive events.



**Figure 3-8: Process of focus coding**

At this stage, the constant comparison method was used to compare the relationship between one category and other categories and subcategories explored, and the term is raised to concepts. New connections of categories are established through linkage among categories with subcategories defined.

This process created a tree of nodes and their relationships presented with hierarchical structure (see Figure 3-9). The codes later assigned to theoretical codes that described the level of uncertainty, contributing factors to disruptive events and mechanism developed to cope with uncertainty.

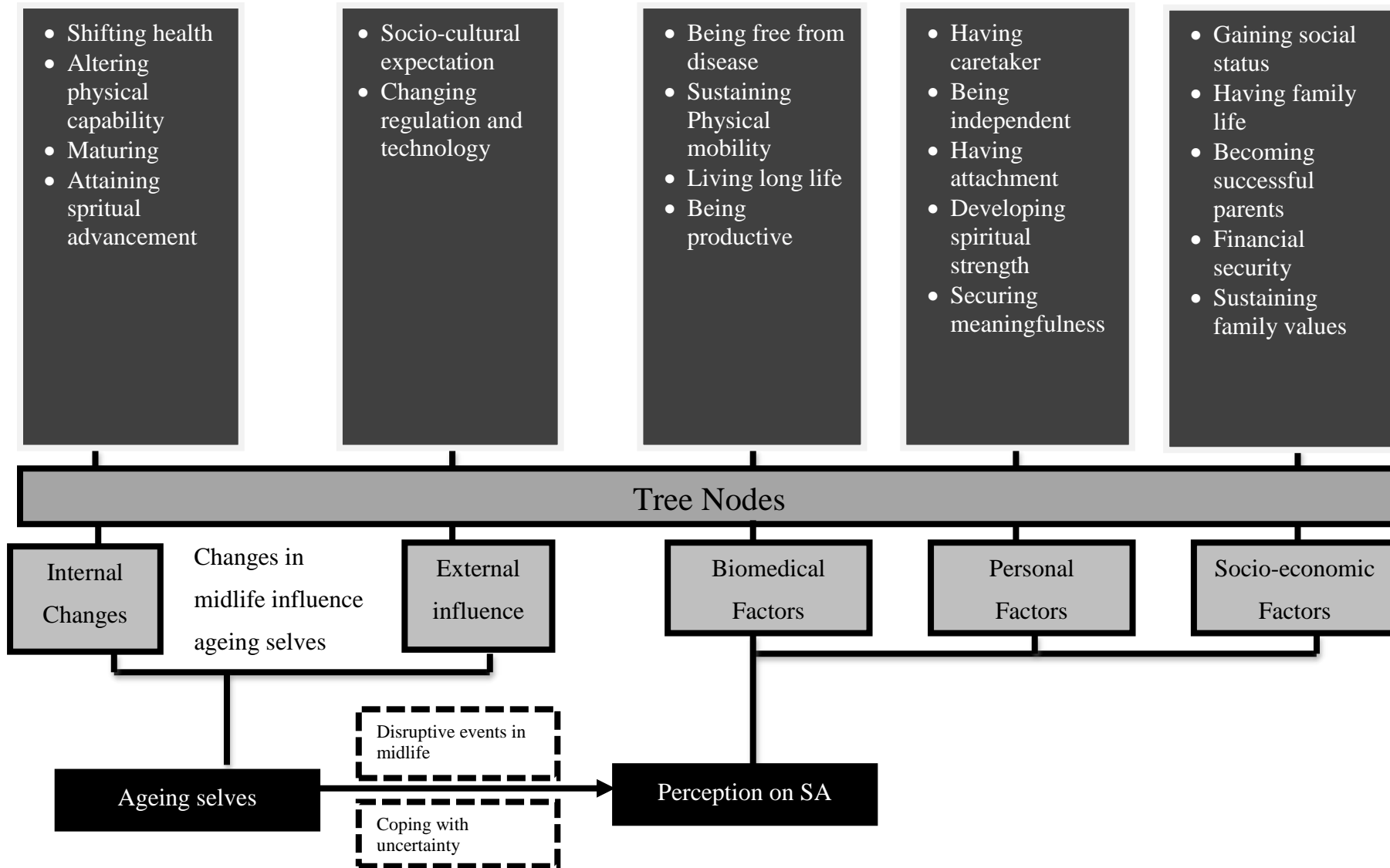
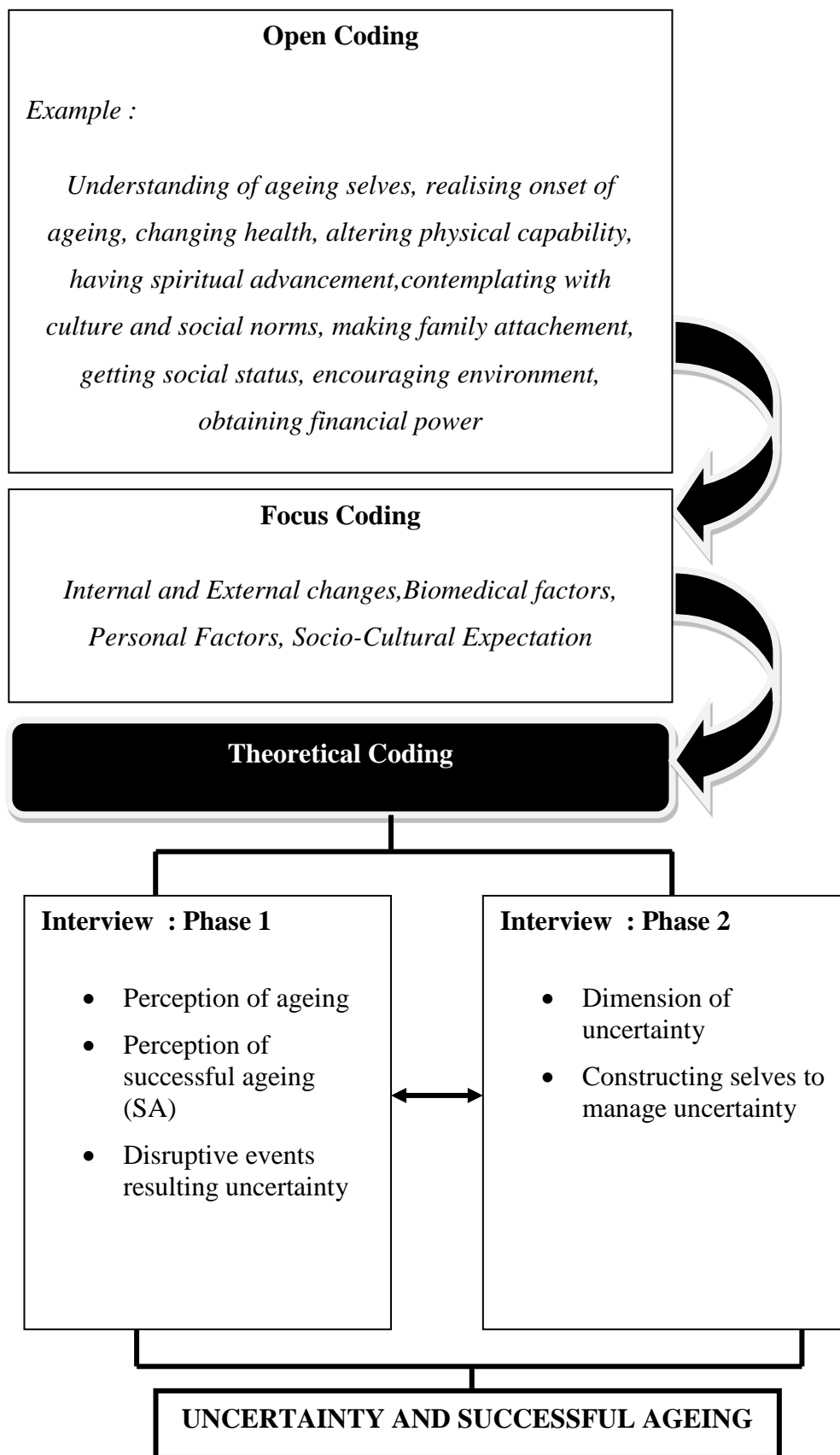


Figure 3-9: Process of categorising data

## **Theoretical coding**

Further data collection and analysis produced categories, where some categories were combined and analysed to create patterns of relationships between two or more categories. In Grounded Theory Methodology (GTM), the researcher has the flexibility to obtain variations among concepts and to condense categories (Goldkuhl & Cronholm, 2010). This process leads to substantive codes, which are then compared with a ‘family’ of theoretical codes and matched according to conceptual categories. Finally, the theoretical codes give order to the relationship between the categories, thus forming a theoretical model (Chenitz & Swanson, 1986). As skills in coding and theoretical sensitivity are essential in GTM, I focused closely on both coding and constant comparison (see Section 3.5.4) in order to generate a theoretical perspective (Strauss & Corbin, 1997b).



**Figure 3-10: Process of theoretical coding**

In the Figure 3-9 the process of arrival at the theoretical codes about uncertainty and successful ageing defined. The coding in Phase 1 also provides ideas for memo writing, and vice versa, which then leads to theoretical sampling (Lapan et al., 2012). Some of the coding examples, along with memo descriptions, are provided in Section 3.5.5.

### **3.5.5 Theoretical sensitivity linking to memoing and data analysis**

Theoretical sensitivity is a multidimensional concept that comprises the researcher's level of insight into the research area, their ability to extract the complexity of the participants' words and actions and to reconstruct meaning from the data and a capacity to 'detach irrelevant data from the pertinent' (Strauss & Corbin, 1990, P44). There is a dependence on the researcher's immersion in the emerging data to increase their theoretical sensitivity. Various methods therefore are used in data collection to stimulate reflection about the data at hand to increase validity of data collected (Corbin, 1998, P22).

CGT provides a theoretical understanding of the perception of ageing by studying a range of individual cases and extrapolating from these to form a conceptual category through a systematic research approach (Charmaz & Bryant, 2007). CGT is described as being 'epistemologically subjective' and 'ontologically relativist' (Mills, Bonner, & Francis, 2006). Through this lens, constructivism brings a relativist stance which assumes that the theoretical analyses are interpretive renderings of experiences and not objective reports of them (Charmaz et al., 2007). In other words, the meaning is constructed through the researcher's interpretive understanding of the data. An emic perspective is one which recommends the study of a particular culture in terms of its internal elements and their functioning and which assumes a relativist and reflective stance towards the data (Denzin & Lincoln, 2003).

In line with the constructivist stance, I acknowledge that my relationship with the external world (Huby, 2011) could be socially contracted with the Malaysian society that serves the data (Charmaz, 2014b; Charmaz & Bryant, 2007). For instance, I used my experience and background to help in understanding the studied phenomena.

Furthermore, CGT enabled the accommodation interactions between the research participants and myself as the researcher, from the beginning to the end of the research.

Hence, for the present research, stepping into the field of investigation and associating general ideas of the ageing process helped the researcher to acquire theoretical sensitivity and understand the context in which the theoretical understanding is developed.

The theoretical understanding constructed following the above process contains interpretative elements because it relies on empirical observation and the researcher's interpretation. In this study, the theoretical understanding depends "on the researcher's view; it does not and cannot stand outside of it" (Charmaz, 2014a, p. 239). Constructivist approaches prioritise phenomena and view both data and analysis as shared experiences and relationships with participants and other sources of data (i.e. Memos, observation, patient records) (Charmaz et al., 2007; Charmaz, 2014a).

Memoing is another important feature of qualitative research that is used to generate knowledge of human behaviour (Birks, Chapman, & Francis, 2008a, 2008b). It is a process used by analysts to keep track of what they think about the data. It is regarded as an essential process in data analysis due to the fact that it consists of the writing up of theoretical ideas, which is separate from data that focus on the relationships between codes and their properties. Memoing allows for a conceptual refinement of the categories in a critical and constructive way. Therefore, writing memos and analysing data are parallel processes that work together throughout the research (Charmaz, 2014a). In order to capture the ideas and recurring themes noted in the data, I wrote memos from the time I conducted the first interview (see Section 3.5.5).

Memoing provides a platform for examining data at a greater level of abstraction of the relationships and explanations contained within the data (Birks et al., 2008b). Memoing is constantly and continuously enriched with additional information at every stage, including:

1. Identification of the categories from the various codes that were developed by taking into account the initial responses of the interview participants. For

example, one of my memos highlighted to me how the risks observed in the present or the potential risks anticipated in later life might alter the already defined ageing.

**Table 3-4: Example of initial open (line-by-line) coding and focus coding**

Interview excerpts	Initial coding	Open coding	Focus coding
<p><i><b><u>“I don’t have children, so in the future, surely I and my wife <u>can’t rely on anyone.</u> It is quite difficult for us, and that is <u>one of the main risks.</u> We also <u>quite unprepared or secure for our later life,</u> but we planned to buy a few houses and rent them. We will try to complete the payment for these houses before retiring. So, <u>the rent will help our survival in old age.</u>”</u></b></i> – <b><u>Yong</u></b></p>	<p>Living childless</p> <p>Limiting assurance in the future</p> <p>Planning after retirement</p>	<p>Obtaining socio-economic stability</p>	

The initial line-by-line coding for the above excerpt was ‘living childless’, ‘possessing unsecured future’ and ‘planning retirement’. However, I later re-coded these to ‘obtaining socio-economic stability’ for the focus coding based on a memo below:

**Example of Memo: Disruptive events:**

*‘These initial codes at first seemed to describe the importance of having a family in securing well-being in the future. However, after going back and forth with the data, I realised the incomplete family structure actually caused accelerated disruption into their anticipated ageing especially in term of socio-economic stability. For example, being childless was associated with risk that already presented in old age and giving greater impact such as not having a carer and financial supporter in the future. It therefore produced an unclear future...’*

2. Determination of the relationship between the various categories by linking them to each other, resulting in the consolidation of the various similarities and dissimilarities existing between them. One of the examples compared and contrasted ‘disruptive events’, which were mentioned by the participants to address the similarities and differences between them. By doing so, I found that the disruptive events varied in the level of uncertainty produced and this was developed in the memo below; see also Appendix 25:

**Example of Memo: Identification of the impact of disruptive events on the level of ambiguity:**

*‘I could sense that the participants making a clear note of the ambiguity they felt in the future was based on the intensity of risk observed from disruptive events. Among the risks identified by the participants during the interview were issues around their health status and the dependency and emotional distress related to issues with children, etc. That were identified as elements of good ageing. Although these variables were interpreted as highly risking the later life, I saw some variance within the level of ambiguity. When the risks associated were lower, the participants were positive of achieving SA, and vice versa. I noticed the variance given to the level of risk based on the different situations in the participants’ life; their consciousness that they felt by crossing the past and present circumstances that aspire the future. Those who acknowledged the risks were able to negotiate their ageing according to the risks encountered; in contrast, the participants who were not cognitive of the actions required were stuck with the existing ambiguity, underwent tremendous emotional distress and felt apprehensive of venturing into their old age.’*

The creation of sub-categories will eventually lead to the construction of the main themes, which subsequently contribute to the formulation of the theoretical perspective.

The following Table 3.3 outlines an example of the coding stages from one participant’s interviews.

**Table 3-5: Example of initial coding, focus coding, sub-category and core category**

<b>Interview excerpts</b>	<b>Initial Open coding</b>	<b>Focus coding</b>	<b>Sub-category</b>	<b>Core category</b>
<p><i>“..In these periods, I <u>hope for good things</u> and <u>pray that I won’t get tested with hard stuff</u> (pause; voice lowered), I meant to say hope to get better. ... I’m hoping for good. <u>Muslims say that is ‘hikmah’ – there is something hidden that we do not know.</u>” - Kamaruzaman</i></p>	<p>Hoping for good things to happen</p> <p>Looking for hidden benefit</p>	<p>Developing hope</p>	<p>Forming spiritual strength</p> <p>Accepting adverse condition- Al-Qadar, fate or karma</p>	<p>Being resilient</p>

**Example of Memo: Being resilient**

*‘In spite of facing a failing body and emotional turbulence owing to children’s failures in life, Kamaruzaman built emotional strength through spirituality and sought guidance from his late parents. Through spirituality, he developed calmness and a fighting spirit. The more I looked at his data the more I learned about his flexibility towards a situation and how he created inner strength and kept moving forward. Not*

*only Kamaruzaman, but other participants also told of their resilience on how they form themselves with elements that may help them to handle conflicts and difficulties; whether it be emotional coping or the support they sought from other people.'*

3. Arriving at the core categories that include a clear understanding of the sub-categories that these core categories represent.

While memo writing includes descriptions and reasoning for each coding, I also included queries about any gaps noticed in the data. For example, I realised that the participants told of how they reconstructed their selves into actions to improve their wellness. However, I realised that they also narrated how they naturally reconstructed themselves into these actions as a mechanism for coping with uncertainty. In the theoretical sampling process, I therefore gathered additional data through activities (e.g. Responding to a vignette, mapping activities, etc.) To understand how the process of the reconstruction of 'self' occurred.

The memo also included my expertise, experience, reflective journal (see Appendix 26) and knowledge of the culture to a certain extent and may thus have assisted in delineating the structure of this study and the process of analysis that led to the theoretical abstraction. Having a reflective journal makes the process of data collection and analysis visible and is thus an accepted practice in exploratory research such as constructivist and feminist perspectives (Denzin & Lincoln, 1994).

### **3.5.6 Strategies to enhance rigour**

CGT provides structured strategies throughout the research process that ensures rigour in the process of data analysis and selection.

#### **3.5.6.1 Credibility of data collected**

The researcher of the present study pursued the study in understanding the perspective of successful ageing in accordance with the insights she gained from the empirical materials gathered on the topic of ageing and SA. Through constant comparative analysis throughout the data collection, she discovered the initial meaning of SA, as perceived by the research participants, and the criteria that influence SA. This led to the need for subsequent data collection through theoretical sampling. The theoretical

sampling stage was deemed necessary to sharpen the focus of the present study, and the Phase 2 data were collected and constantly compared with the events and views from the first participant from Phase 1 data analysis (see Figure 3-6). The codes were then compared with the second participant, third participant, etc., with this process being repeated until all categories had been completely identified and the relationships between them assessed or integrated. These activities guided me and sustained the rigour of the study with a progress from a description to a conceptualisation of ageing successfully until a theoretical understanding was refined and formed in relation to how middle-aged people reconstruct themselves to increase their ability to cope with uncertainty and age successfully.

### **3.5.6.2 Understanding of social phenomena without preconceived ideas/theories**

Another value of CGT is that it provides methodology to develop an understanding of social phenomena without preconceived ideas or theories (Engward, 2013). Although CGT rejects adductive reasoning (e.g. The researcher enters the field of research without any single knowledge/theoretical explanation until the research arrives at the most plausible explanation), which is a logic taken from classic GT, it does endorse its epistemology (Wertz, 2011). Therefore, the strength of CGT lies in its avoidance of making assumptions that it can “get to the real problem”. It adopts a more neutral view of human actions in social contexts (Simmons, 2006, p. 489).

Since GT methodology (GTM) offers a set of general principles, guidelines, strategies and heuristic devices rather than formulaic prescriptions (Charmaz, 2014b), it allows the researcher of the current study to be flexible, creative and interactive with the strategies employed for data collection. However, if I had to enter into the data collection phase with a completely open mind, I may end up with a diverging amount of unfocused data. Therefore, the researcher of the present study agrees with Goldkuhl and Cronholm (2010) that the researcher needs to define a relatively explicit set of research questions that are not too restrictive but that do support and govern the data collection (Goldkuhl & Cronholm, 2010). Other researchers have also highlighted that although GTM comprises a systematic, inductive and comparative approach for conducting an enquiry of the studied phenomenon, it also includes flexible guidelines

for collecting and analysing qualitative data (Charmaz & Bryant, 2007; Lapan, Quartaroli, & Riemer, 2012).

### **3.5.6.3 Triangulation in data collection**

In Grounded Theory the data comparison combines several types of data, such as that obtained from observation and interviews (Cooke, 2014). In the present study the data from a variety of different sources (i.e. Analysis of interviews against activities such as using vignettes in second interviews) in the initial interviews, and interviews conducted during the theoretical sampling were not different in terms of their perspective (see Section 3.4.1 and 3.4.2). This variety of sources helped to validate and develop the initial coding.

Therefore, the researcher in the current study does not see the use of multiple techniques in CGT as a challenge but rather as a strength (see Section 3.5.6.3).

### **3.5.6.4 Credibility and conformability**

Only individuals capable of conversing in Malay or English were recruited, and all of the participants were interviewed in the Malay language. Of the participants 25% of them had only a primary education, the majority had secondary education and the rest had a higher education (see Table 3-1). The transcripts were not returned to the participants for member checking as most of them had only low-level literacy. However, at the end of each interview the researcher read through the discussion from the notes taken during the interviews.

### **3.5.7 Reflexivity of the researcher**

A range of actions (e.g. Keeping a record of memos, reflexivity, without any preconceived theory) were taken to minimise the influence of my personal reflection and to enhance the rigour of the study (see Section 3.5.6, Appendices 25,26). In addition, secondary data such as the participants' backgrounds, demographic perspective and my reflexivity are also incorporated in the data analysis. The reflexivity in this research also draws upon other factors such as interpersonal aspects and the ontological and epistemological assumptions underpinning the studied phenomena (Mauthner & Doucet, 2003).

I conducted this research in my own community and in an environment with which I am familiar. A few of the participants were my clients for behaviour therapy in the quit smoking clinic; hence, they only know me through my profession. Overall, however, none of the participants in this study knew me personally, but they did know me culturally. My intention was therefore to be careful with feelings of cultural incongruence and issues as well as any complications, especially when giving voices to my interpretative perspectives.

As a woman in her early 40s, I look younger than my actual age, which is a blessing. However, I felt that few of my research participants perceived me as a young girl who was not yet involved in the process of ageing, due to my young appearance. I realised that this became a barrier and challenge when interviewing them when one of the participants said, "you are too young and won't understand what I mean?" I was, however, only a few years younger than him. Therefore, I had to relate to them that I did share some similar identities/experiences with them, such as "I have been living here for the past 10 years and I have passed 40 years now".

Some of the most demanding situations involved some of the male participants crying. I could understand it was difficult for both the male participants and myself. As is the norm in Asian culture, a man is expected to conceal his emotions, with a failure to do so being seen as portraying a weak image in front of a female. I also felt the intense reactions of regret, sadness, worry and the desire to be fulfilled from these participants for what they intended to do. The force of these projected emotions was especially

evident in my personal somatic reactions. These experiences forced me to analyse and understand my own identity. During the first month following my return to the UK after my first data collection, I was overwhelmed with these intense emotions when flashing back to the interviews with participants. Some of them talked about dying, feeling guilty about their past actions and their worries for the future. These experiences were pointed to my inner reactions that were generated from cultural complexity. I had also looked inside myself for comparative experiences. For example, during one of the interviews, I felt critical when one female participant, who was the same age as myself, seemingly wished to get married and have her own family as the ultimate purpose of her life, unlike myself, who has adapted to contemporary thought by living an independent life after my marriage failed. The process of consciousness indeed helped me to listen to the interpretation of my data. I sought to gather the experience of ageing in this community as a set of collective experiences with significant others rather than as personal reflections. I felt that these experiences and challenges have contributed to a deeper understanding of the experience of my participants and also myself. These reflections of the researcher were kept through memoing and structured her thinking according to the emerging themes. This was beneficial for interconnecting the themes that were relevant to events that occurred in the field of study.

As such, ways to manage uncertainty perceived through the construction of self with behavioural control becomes an important aspect to age successfully. In this study the researcher examined the how the participants develop themselves to manage uncertainty in Phase 2 data collection. The research participants construct themselves based on past experience as well as on anticipated barriers and spiritual understanding to manage uncertainty encountered that affects the wellbeing in the future. The motivation to comply with the behaviours that enhance ageing successfully in the future derived from subjective forms of satisfaction such as from family members, spiritual and also perceived behaviour control. A comprehensive detail of the finding is discussed in Chapter 4 and 5.

### **3.6 Key message**

The research design in this study and its methodology was influenced by the CGT developed by Charmaz (2006). A series of qualitative methods was used in the current research: in-depth interviews, mapping activities and interpretation of vignettes. These methods were selected as being the most appropriate for achieving the research objectives. The data were analysed using the CGT approach put forward by Charmaz (2010). The memoing and constant comparative techniques were found to be the strongest elements in the data analysis in this study. The researcher's critical self-reflection had an effect on the research process and decisions taken with regard to the research methods and approaches. All appropriate ethical considerations were also detailed and followed.

The finding presented in chapter 4 and 5 will detail the contents of the conceptual model stated at the end of Chapter 5. The study participants seemed to perceive disruptive events during middle age as a barrier to SA. The disruptive events posed uncertainty that is discussed in Chapter 4. The study's findings in Chapter 4 also explored the perception of ageing and how changes in middle age influence the participants' ageing selves. Chapter 5 discusses the dimension of uncertainty which is influenced by the severity of the disruptive events, knowledge and resource support possessed by the research participants, their assessment about the risks caused by the disruption and the input of time when the narration of the events occurs. It also outlines how the participants in this study construct self to manage uncertainty through

possessing resilience, building interdependence, creating balance between the components that influence SA and by modifying lifestyles and behaviours contributing to SA. Since the participants discussed the behavioural changes and actions taken to reduce the intensity of uncertainty, the researcher also explored the priority accorded to those behaviours against timescales of short-term, medium-term and long-term. In the following Chapter 6, these findings are discussed in relation to the breadth of empirical literature.



## Chapter 4 : Ageing and Disruptive Events

This chapter discusses the findings of this study. Firstly, it describes onset of old age as defined by participants. Secondly, it highlights the changes that occur in midlife that contribute to a construction of ageing. Next, it reports on how participants identify uncertainty. Finally, it examines and classifies the sources that result in uncertainty that is perceived to affect the practice of successful ageing in later life.

### 4.1 Background to the findings

In the initial interview sessions, the participants in this study were asked, “how do you see yourself in five years’ time?” In order to help them define their perception of themselves in the future. However, most of the participants had only a vague notion of what might happen to them as a result of certain disruptive events that had occurred in both their past and/or present-day lives and which they strongly believed would affect them in later life. Although the participants described what they perceived as constituting successful ageing, they also repeatedly raised concerns about the actions that were required to deal with the ambiguity that they sensed around achieving their desired old age. As a result, the uncertainty generated by specific situations and the consequences arising as a result of this are seen as preventing or making it difficult for the participants to achieve the old age that they desire. Below are three interview excerpts taken as examples to illustrate the concern resulting from uncertainty among the research participants.

*“The uncertainties in my life are too big” – Fidaus*

*“I wouldn’t know what would happen in the future. I might be admitted to the hospital again for a long period, or I may not be able to work... In old age when I cannot walk, how is that going to be? Will my children take care of me? Or might they neglect me in the way that I neglected my late parents?” – Salleh*

*“I am hoping for the best, but I am not sure what lies ahead in the future.” – Kamaruzaman*

The behaviour involved in the process of ageing itself demanded an active approach in an effort to establish some sense of certainty for later life. The participants worried

that they would be unable to accomplish their envisioned future unless they were able to survive the threats that were predicted in that future.

One participant, Analya, described her sister, whom she considered to have achieved successful ageing (SA) as someone who had always been sure of her later life.

*“She (participant’s sister) was always prepared for her future. I don’t see that she has issues of instability; her future is secure...She never had a stage in life that made her feel unsure of what to do next or ...err confused about what to do in the future.” – Analya*

The participants spoke further about the importance of tackling these uncertain situations, with the result that the core categories of successful ageing that emerged from the data being centred on the management of uncertainty.

The following sections discuss perception of ageing, followed by uncertainty caused by disruptive events.

## **4.2 Perception of ‘ageing’**

The following sections discuss the participants’ perceptions of old age and successful ageing. It also presents the changes experienced in midlife and how these have led them to raise their coping behaviours with uncertain events.

### **4.2.1 The onset of ‘old age’**

As mentioned in Chapter 3 (see Section 3.1), the aim of this research is to understand the life course attributes that impact on the later life of middle-aged Malaysian adults. Hence, the participants were asked, ‘what age do you perceive to be the beginning of old age?’ The participants in question were aged between 55 and 57.

The majority of the participants believed that old age began in their 50s, which is earlier than the working definitions of old age set out by the World Health Organization (WHO) and the United Nations. The WHO (2002b) defines the start of ‘old age’ as 65 years, with the United Nations adopting the standard criterion of 60 years and above.

For instance, 7 out of 16 participants identified their 50s as the onset period of ‘old age’. One participant stated that old age began at 40, and 3 participants highlighted

that it began at the age of 60. Only two participants stated that old age did not begin until 70. However, the remaining participants felt that they had already sensed their old age at the time of the interview, noting, *“I could feel I am old now”*.

*“So, I’ll say probably at the age of 50; we become old.” – Maniam*

*“In my opinion, if we are 50 years old; we are old.” – Firdaus*

Of the five participants (31.25%) who mentioned that old age is above 60 years, 80% of them are healthy participants.

*“I feel being ‘old’ is a personal thing; it is up to the person. I think above 60 is old.” – Siti*

*“40 is categorised as neither old nor young. I just cannot make such a categorisation. I think in the 40s; where we are at a stage progressing towards old age. Perhaps someone in their 70s could be regarded as elderly.” – Analya*

In general, I noticed that the perception of the onset of old age among the participants was highly related to the changes in social roles and cultural analysis rather than the chronological definition of ‘old age’.

#### **4.2.2 Changes in midlife that influence the ‘ageing selves’**

The factors influencing the notions of ‘old age’ were based on the changes experienced by the participants on a physical, psychological and cognitive level during midlife. These significant changes in midlife contributed to a ‘constructing of self’ to old age through internal changes: ‘shifting health’ and ‘altering physical capability’, ‘maturing’ and ‘attaining spiritual advancement, and external changes: ‘complying with social norms’, ‘regulating self by the effect of retirement policy’ and ‘having a lack of modern technology knowledge’. According to the participants, these changes were also based on the accumulated experiences and skills that they had developed from their youth into adulthood (see Table 4-1).

##### **4.2.2.1 Internal Changes**

The changes identified by participants in term of health, physiological functions and personal growth relating to the mind and emotional strength were identified as

important factors influencing the perception of ageing is presented in the following section.

#### 4.2.2.1.1 Shifting health

‘Shifting health’ describes the onset of any number of health issues. It represents an important factor that serves to accelerate the progression into old age. In this study, the majority of the participants, including the healthy individuals, expressed how they viewed their health status as a critical turning point, thus having the power to change their views of ‘becoming old’ and serving to construct their perceptions of old age.

A total of 90% of the research participants who were suffering from chronic ill health, said that ‘old age’ began between the ages of 40 and 60. These participants mentioned that old age begins early regardless of their age, gender and marital status. As such, these participants seemed to consider themselves as having a much shorter period of midlife compared to the healthy participants. As a result, ill health had served to hasten their entry into old age.

The responses below from two participants suffering with a heart condition, one woman and one man, best illustrate this claim:

*“I thought in the past, 50 was old. However, now I think after being diagnosed with the illness, I’d become old at the age of 45; even in early 40s, one can be considered old.” – Salleh*

*“I think 50 plus, ahem, I am old already. One foot is on the ground already, in the 70s it is like waiting to go off already!” – Shiela*

Changes in health status also seemed to act as an automatic reminder of old age, with two examples from the data quoted below:

*“We always thought that we would be young forever! We felt that we would be okay forever! At the age of 56, when the doctor told me that my heart vessel had narrowed, ah, at that time err, I came to an awareness myself. Well, I am not dying. However, it means that God is reminding me, ‘huh; you think you’re still young?’” – Kamaruzaman*

*“... we can’t prevent it (illness) as we age. In my 40s, I feel like I’m old already!” – Salleh*

As mentioned above, a decrease in health for many participants is a cue for ageing. However, some of the participants mentioned that people in the present compared with older generations were viewed as more energetic, active and may feel younger than their actual age.

*“Nowadays, people at the age of 70 still look energetic. I would say the age between 75 and 80 years is considered aged. People aged 70; they still can work and get about. That means they are okay.” – Karim*

The data above suggests that, for many of the participants, changes due to health issues were accepted as being linked to the ageing process and that they come with a deteriorating body.

#### **4.2.2.1.2 Altering physical capability**

The data showed that changes in physical ability were the outcome of both health issues and a natural decline in bodily strength. The health issues mentioned by the participants implied constraints to physical ability and also appeared to modify their physical development (e.g. Limiting mobility and the capacity to perform daily chores). In addition, certain treatments and their side effects, such as dialysis, could also affect the participants’ strength level.

One participant compared his younger days with his current physical ability and stamina when reflecting on the differences:

*“My energy is going down... I get exhausted quickly. Before now, I used to feel refreshed with only 4–5 hours of sleep. But, eh... now, I need a solid 6 hours of sleep, sometimes even up to 7–8 hours of sleep. ... I can’t drive a long distance without sufficient breaks. This could be because of the age and illness. Both have impacted on my energy level.” – Yusof*

The above participant, Yusof, recognises that the combination of his ageing and current health status has reduced his physical ability. The evidence from the data show that a decline in physical strength due to the advent of life-threatening illness increases the possibility of physical changes, with the following participants seeming to lose sense of their previous self.

*“With my heart problem, I can’t even climb to the second floor without a break. Before arriving at the fifth floor where my house is, I’ll stop several times. These days I just keep myself to the possible level of fitness and don’t force myself.” – Firdaus*

*“Having pain in my joints, nerves, tiredness and dizziness all make me weak. Previously, when I was young, I did not have any of these problems. The body generally, when turning 40, it starts to deteriorate.” – Shiela*

*“My body isn’t strong anymore. I have pain everywhere. When you are old, physical discomfort is a great concern.” – Noor Anis*

For these participants above, the physical changes in their selves were sudden and unexpected events that led them to re-evaluate their selves to the current physical strength. On the other hand, most of the unhealthy participants thought that physical inability was linked to possible future immobility as part of a broader pattern:

*“I think that out of ten people, probably only five will be physically active. Depending on our fate, some really can do well.” – Karim*

Both the unhealthy and healthy participants highlighted physical immobility as part of the ageing process rather than as being the cause of their ill health. Maniam, a working male participant, mentioned that he felt challenged by the decline in his physical health, but that he considered this to be a sign of ‘becoming old’.

*“... at this age, I feel anxious, cannot do hard work anymore. I am even scared to ride a bike. Often, I feel as if I am losing control while riding. I realise that I have become old now; lack of strength, obviously I could sense the difference in myself between my younger years and now. My level of speed has decreased; I was an active person in the past. Now I can’t even climb the stairs without feeling weak and dizzy. After a long walk, my legs will shake; an indication that I’ve become old.” – Maniam*

Similarly, another participant in his 40s compared the changes that had occurred in his physical ability between his youth and now.

*“In my 40s, I found myself getting tired easily. Before this, I was an active and sporty person. However, now I don’t feel the same enthusiasm these days. In my 20s, I played sports, worked and did other things all at once. I had never felt it this way...” – Salleh*

The reduction in physical capacity and mobility experienced by the above participant made him feel old at the age of 50.

#### **4.2.2.1.3 Maturing**

The participants mentioned maturity as a change that indicated the progression of age. For example, other members of society saw the older people as having a better understanding of life due to their years of experience and by virtue of the fact that they had almost certainly survived a variety of tribulations along the way. This meant the older adults should be mature and wise. They were expected to be exemplary figures, not just amongst family members, but also for others in their neighbourhoods. For some of the participants, the important factor of ‘becoming old’ seemed to relate to years of experience and the way they had handled challenging events in life.

A female participant in her 50s considered that changes in personality usually occurred as people became older and more mature, such as in the way they communicated, the levels of thinking and understanding and having different perspectives on life.

*“When we become old, our thoughts can be different. The way we communicate will be different based on our mature thinking. We will make peace with others, if possible. Our maturity is based on our age, and it relies on our past experiences.” – Ayu*

Being mature is synonymous with being an older adult, with the data suggesting that the older people need to carry an image of maturity. The data below are taken from three participants of different gender mentioning the maturity gained with advancing age.

*“I think when we get older, we will change in the way we think and our attitude will change. From an aggressive person, we may turn to a passive person. That’s the course of nature and is seen as a normal transition of a person.” – Siti*

*“I have reached a level of maturity...have seen more things... I was naive when I was young, but now I’ve developed an analytical mind that sees both positive and negative sides in each person and everything...” – Shiela*

*“...as an elder, we are supposed to be an example. So, the children will grow up with better behaviour in the future by looking up to us.” – Karim*

In addition, the data suggest that maturity appears to be associated with the respect received by the older people in some way. However, the respect given to the older adults was not only based on the level of maturity but was also closely linked to personal achievements, the respect earned by the family in the past and the social role held by the person (see Section 4.4.1).

Nevertheless, only 9 out of 12 participants in the study considered maturity as a sign of development and change towards old age when asked to prioritise the landmarks for 'becoming old' during an activity in the Phase 2 interviews. Although the participants in the initial interview highlighted a decrease in the members of the younger generation who respect older people, the element of 'respect' seemed to be disconnected from old age. The majority of the participants did not identify 'having respect from others' as an important aspect of old age during the activity mentioned above (see Table 4-1).

### **Attaining spiritual advancement**

The level of spiritual attainment was seen as a resource that intensified with increasing age. Spiritual attainment was noted as an important shift towards old age. The expectation of having been furnished with spirituality in later life was recognised and developed both in form of external and internal evolution. The data suggested that the awareness of gaining spiritual enrichment grew or intensified with increasing age. The participants expressed that spiritual attainment was sensed as an inevitable part of ageing. They viewed it as being learned through the images portrayed by the other older people in society and from reflecting on their own experience of living with their parents.

*"I feel that the older generation are more inclined to religious activities. I think when you become older you tend to get closer to God." – Yong*

A majority of the participants attached a higher priority to spiritual attainment as a prominent factor of 'being old'. One participant, however, indicated that spiritual attainment was not related to the perceived image of her old age (see Table 4-1).

Additionally, most of the participants, regardless of their health conditions and gender differences, voiced their opinions about dying. Since most of the participants were

acutely conscious of being on the cusp of old age between the ages of 50 and 60, both the healthy and unhealthy participants perceived sensing death as a certain signal of old age. The sense of dying was noted more strongly among the unhealthy participants, who felt that might have only limited lifespan remaining. The need to connect themselves with spiritual activities seemed to be crucial in the present, as it would nourish them in readiness for the afterlife.

Many of them talked about death, as described in one of the meaningful responses:

*“In younger age, we were less spiritual compared to how we would be when we reached old age; I think i’ve become more religious now. That is normal, as, at this age, we think about death and become emotionally inclined towards life after death. Yes, it is the time for me now to fill up myself with religious practices.” – Khadtijah*

Spirituality was also an important part of creating resilience; see ‘Being resilient’ in Chapter 5, Section 5.2.1.1.

#### **4.2.2.2 External influence: Socio-cultural, regulation and technology**

In this studied population, social landmarks or certain norms were associated with images of old age that were shared by members of society (e.g. Having grown-up children or being reaffirmed by common incidents such as the shared experience of chronic illness among middle aged adults in society).

Such self-perceptions in adapting to old age are thus regulated by life events that are accepted by society as norms, regulation and an advance in technology that indicate old age.

##### **4.2.2.2.1 Having grandchildren/married children**

A 40-year-old single female participant revealed how her feeling of ‘becoming old’ was influenced by the opinions of those around her.

*“I don’t think that I’m old...I’m still young, that is the truth. Only the year that I was born, in 1975, is saying that I’m forty years old... Of course, when someone says that I’ve turned forty and old, at that*

*moment for a while I think, 'yes, I'm old and get a bit nervous'.*" –  
Analya

A female participant in her 50s with four grandchildren and who was married to a person much older than herself, felt that she was already old.

*"Being old is the relative description and is defined by custom. At the age of 17, I got married and now I already have grandchildren. That makes me feel old. My husband is very much older than me, and also when people call me granny, I feel that I've become old."*  
– Ayu

A mother of two in her 50s shared the same perspective of having grown-up children as a sign of becoming old:

*"I was very young when I got married. Now, my elder son is expecting his first child, and I am excited to be a grandmother. I am in my old age already."* – Kamsiah

The female participants were not the only ones to mention this notion of old age being linked to having grown-up children; a male participant also shared a similar view:

*"It is true that when our children become adults and get married and when we get grandchildren, it means that we are old."* – Karim

However, the above participant also mentioned that some men who remarried in old age might do so because they still felt young and were capable of taking on new responsibility. He referred to one of his friends as an example.

*"Some of my friends, one, for example ... even at the age of 75, looks super good and remarried! (laughed). If he had felt old, he wouldn't have remarried...when we look at it, if he thinks he is old, he wouldn't want anything that would be a burden to him ... if he can manage another person in his life, that means he is not old yet."* – Karim

The above excerpts from the research participants reveal a connection between old age and the symbolic value given to the meaning of old age by society. Consequently, becoming a grandparent is included in the identity of a person who has earned respect as a senior or a mature member of society. Moreover, in Malaysia, a grandmother is referred to as 'nek' and a grandfather as 'atok', which are terms used to denote an older person and are acceptable norms to use when addressing the older adult in this culture.

However, from the data, it is unknown whether childless individuals or people between 50 and 60 years of age with relatively young children also regarded themselves as elderly.

#### **4.2.2.2.2 Having shared experience with a chronic illness**

The data indicate that certain incidents take place within a wider context and that these are thought to be a common condition of old age. The participants tended to affirm their opinions of ‘becoming old’ based on those incidents. For example, a participant in this study asserted that he perceived he was ‘becoming old’ at the age of 40 when he looked at peers of his age who were also suffering from health conditions. As mentioned in Section 4.2.2.1, the community viewed health issues as indicators of old age, and when many people have chronic illness in midlife, this produces the concept of old age at an earlier point than a purely chronological age may suggest. For example, the below-mentioned participant felt that he had reached old age at 40 and was affirming his notion with the indication that many of his friends had also developed chronic illnesses at an early age.

*“...many of my friends in their 40s already have a chronic illness such as diabetes. Some of them have had a leg amputated. They are 40 years old, just like me! Therefore, I think at 40 years old we have become old. Maybe it is an early phase of ageing...” – Salleh*

#### **4.2.2.2.3 Regulating self by the effect of retirement policy**

The compulsory retirement age set by the Malaysian government also had an impact on the notion of when old age begins in society. For instance, when someone is retired or has been officially announced as withdrawing from an active working life, society in general comes to regard him or her as old. In Malaysia, under the new law of the Minimum Retirement Age Act 2012 (Ministry of Human Resources Malaysia, 2013)<sup>1</sup>, the mandatory retirement age from public service was raised from 55 to 60 years in

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<sup>1</sup> The Ministry of Human Resources is the ministry of the Government of Malaysia that is responsible for skills development, labour, occupational safety and health, trade unions, industrial relations, labour market information and analysis, social security and labour acts.

2013. One of the male participants compared his old age with the official retirement age.

*“I consider myself old after retiring, maybe at the age of 55.” –  
Yusof*

#### **4.2.2.2.4 Having a lack of knowledge of modern technology**

Two participants perceived a lack of knowledge and skills regarding modern technology as a sign of old age and as subjective indicators of old age. These two participants mentioned that a lack of knowledge of technology was related to old age at the time they were engaged in Activity 1 during the theoretical sampling (Phase 2) that was conducted to collect further data (see Chapter 3, Section 3.4.2). However, the remainder of the participants discounted this aspect of a shortfall in technological knowledge as having a significant association with old age

**Table 4-1: The prioritisation of landmarks for 'becoming old' by the participants collected during Phase 2 data collection**

Perceptions of ageing (n=12)	Prioritisation			
	High	Medium	Low	No association
Becoming old means I become closer to God and more spiritually connected.	9 Participants	2 Participants	Nil	1 Participants
Becoming old means I have changes in health status / visible physical changes are noticed.	9 Participants	2 Participants	1 Participants	Nil
Becoming old means I do not need to work productively and have more leisure time.	5 Participants	4 Participants	1 Participants	2 Participants
I am ageing when I am financially secure for later life.	2 Participants	5 Participants	1 Participants	4 Participants
I am ageing when I become a grandparent.	2 Participants	2 Participants	3 Participants	5 Participants
I will consider myself as becoming old when I become wiser and hence become a good example.	2 Participants	7 Participants	1 Participants	2 Participants
Becoming old means I have the respect of others.	Nil	4 Participants	4 Participants	4 Participants

I will consider myself old when I behave like a child again.	1 Participants	2 Participants	4 Participants	5 Participants
I will consider myself old when new learning in technology is needed.	1 Participants	Nil	1 Participants	10 Participants

Overall, the participants describe both objective and subjective factors that influence ageing (see Table 4-1). The objective factors are mostly about the consequences of health and physical decline and the main subjective factors mentioned are about the maturity gained through spiritual understanding and the social norms associated with ageing. Uncertainty perceived in the middle age derives the perception and actions taken to age successfully in later life. The following section discusses how the research participants recognise uncertainty posed by disruptive events.

### 4.3 Identifying uncertainty

The ambiguity that the participants sensed in relation to old age was described as a ‘disruptive event’. Analysis of the data demonstrates that the participants’ perceptions of old age and SA shaped the way they identified uncertainty. Nevertheless, not all disruptive events were perceived as creating uncertainty in the future, and the severity of the ambiguity depended on what the participants desired in later life.

Most of the participants perceived middle age to be a period in life that entailed a significant crisis, due to either ill health or non-health-related events, in comparison to other phases of life. Since disruptive events are unexpected and undesirable, the participants felt that immediate attention should be given to the consequences of these events as well as to planning and adjusting to their present undertakings, especially in relation to issues concerning their future well-being. As such, it was crucial to understand how the participants from this particular cultural background dealt with the uncertainty of the crises they met in midlife to enhance the quality of their later life. The data indicate four types of actions that were undertaken by the participants when seeking to manage the uncertainty in their later life: 1) ‘possessing internal control’, 2)

‘building external support’, 3) ‘creating balance’ and 4) ‘modifying lifestyles and behaviours’ (see Chapter 5, Section 5.2 and Figure 3-11)).

These actions were constructed, learnt and performed instinctively as part of the daily experience developed through the norms and customs practised by the participants in the community. For these research participants, these actions were based mainly on the collective efforts of family and society as a whole. The next sections detail on how participants recognise disruptive events.

### **4.3.1 How participants identify disruptive events**

Later life is an unknown and unexplored stage. Nevertheless, the data from this study show that it might be possible to assume or predict the later life to a certain extent through subjective reasoning, the risks identified for the future, past experiences, personal beliefs and the ideas obtained by individuals from culture and religious awareness. Using this subjective judgement and perception, the participants appeared to connect, compare and frame their future ‘self’ with others from their previous generation or with people, they knew. The participants also reflected on their future life stage, anticipating risks based on their current experiences and past events.

Overall, the participants in this study identified disruptive events via two distinct processes of learning:

#### **1. Primary (Self): Through the experiences and incidents they had encountered directly in both the past and the present.**

The participants identified the uncertainty of the situation based on a variety of complex, unexpected and unforeseen events that they had directly experienced. These events had been extremely disruptive and affected the participants’ regular activities.

This was due to specific risks and forced alterations to their already planned activities. The participants had suffered as a result of a range of conditions, and these were not limited to life-threatening health events, relationship problems, job security and/or financial loss. For example, participant Maniam related his health status and Firdaus related financial insecurity with the complication they might face in later life.

*“The disease I’m suffering now is shaking me ...the older age will be harder”– Maniam*

*“I never prepared ...I don’t have insurance”– Firdaus*

In some cases, the circumstances arose not due to a sudden change or situation but rather as a result of long-term conditions that were already present in their lives and which, over time, had grown to become major issues for their well-being in later life. These prolonged conditions included things such as their state of childlessness or a poor relationship with their children that they had not previously anticipated as becoming major barriers to SA (see Section 4.4.1.1.).

## **2. Secondary awareness: attained from incidents anticipated and shared experiences by family and others in the community**

The data show that the participants interpreted their secondary experience with others, which created a more complex array of emotional experiences. They believed that they might also encounter a similar kind of incident in the future that was based on these basic underlying factors. Those participants who had drawn on the experiences of others, which they retained mostly in their unconscious minds, were afraid of what might happen to them in the future rather than what was actually happening to them.

Participant Kamsiah associated her existing relationship issue with her son with the death of her husband’s friend who had been neglected by the family members.

*“My husband’s best friend was very ill due to diabetes and hypertension...his condition became chronic. One week later, we heard that he had been admitted to the ICU...three months after being discharged he died, ... actually, he was staying alone in the mosque with no one to take of him, neither his wife nor children...I was saddened by the way he died. Why did he have to die as an orphan in the hospital while he had a family? I do not want this situation to happen to me...I am scared, especially since my elder son has moved out to stay in different house with his wife.” – Kamsiah*

Another participant, Noor Anis, foresaw that she would become highly immobilised in the future due to her health condition, or that she may end up having her leg

amputated in the same way as her neighbour who had suffered from a similar health issue.

*“Anything that happens to other people becomes an awareness for me. If possible, I don’t want those things to happen to me. For example, for there to be no one to take care of me, or for me to become immobilised. People’s lives can change overnight due to a health condition. So, the risk is the condition of the problems that encountered by a person.” – Noor Anis*

One participant, Shiela, was worried about being left alone in her old age without a caregiver, similar to the way a childless friend of hers had been.

*“My friend said she has already made plans for old age. She is now in her fifties and childless. If she is bedridden, she doesn’t want to continue being a burden to her siblings... That is also part of the process; it is the quite the same for me.” – Shiela*

The above quotes emphasise that the participants associated their current situations with the future potential consequences through issues that had been experienced by the people around them. In addition, the awareness obtained through this secondary experience was mainly noted from two types of people: those with whom the participants had a close relationship (e.g. Their family members, relatives, work colleagues and neighbours) and those who were having similar problems as themselves (e.g. Who shared similar conditions and underlying factors, that is, health conditions and/or personal problems).

*“Actually, [it is] the factors around us that cause the uncertainty and not our consciousness. When we are in the affecting factors, we tend to observe people in the same factors that [are] linked to us.” – Yong*

Therefore, it is evident from the data that some issues of uncertainty did not involve the participants directly. However, they relate the issues experienced by other people to themselves due to a certain probability of these things also happening to them in the future, or that the things would happen to them if they failed to manage the risk factors early.

#### 4.4 The sources resulting uncertainty: Expectations from social norms, personal factors and biomedical factors

The research participants reflected that a combination of tensions from social norms, personal struggle to secure meaningfulness and disruptive health resulted in uncertainty associated with successful ageing.

The expectations from social norms centred around parenting, filial piety, social status and children viewed as parental insurance, family traditional values, childlessness, intergenerational disconnection leading to a sense of regret and parenting failure in middle age were viewed as creating ambiguity in achieving successful ageing. In addition, the pressures in form of securing meaningfulness in the later life posed ambiguity when situations occurred that obscured meaningfulness. Meanwhile disruptive health was seen as creating ambiguity in achieving successful ageing in later life with consequences such as loss of mobility, loss of productivity, loss of independence, financial instability etc. Figure 4-1 depicts the key events that contribute to disruptive events.

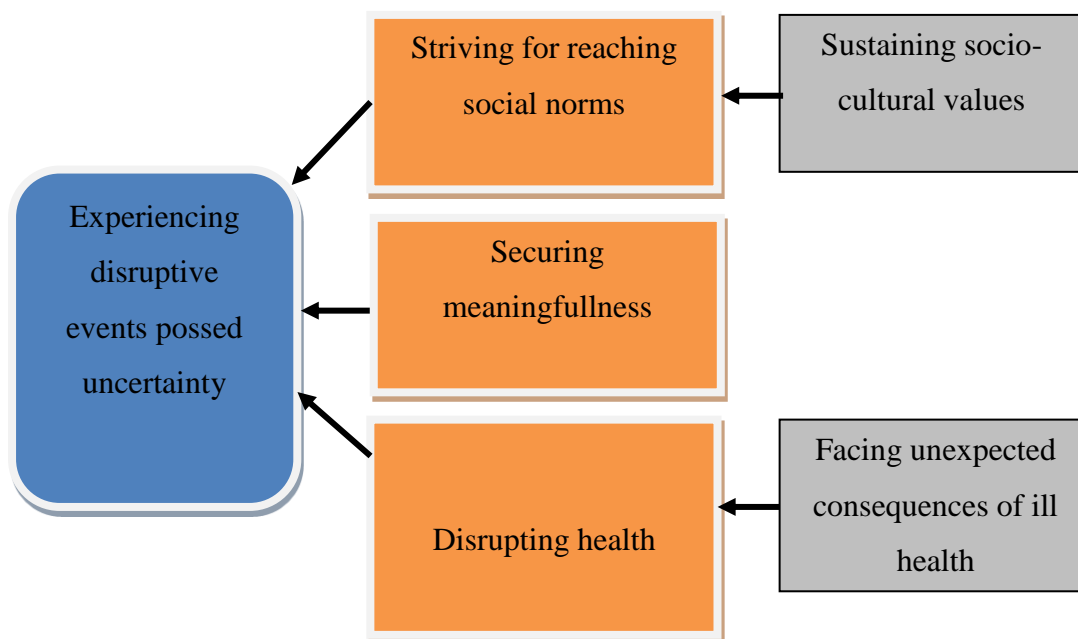


Figure 4-1: Sources of disruptive events

#### **4.4.1 Striving for reaching social norms**

We all have different expectations at every stage of our lives. For example, during our school days, our aspiration might be to excel in our exam results or the sports we undertake. In our adulthood, our aspirations may be geared more towards having a successful career or finding the right life partner. The expectations we create for ourselves form a connection between our vision for the future and the beliefs that we have about our ‘self’ and significant others. Similar to the above personal reflection about expectation, the achievements attained by the participants until midlife were noticed as objective measures that signified their successful selves, with these achievements then forming the basis for their future selves. As a result, achieving a certain degree of fulfilment in midlife is key to what we may be able to objectively draw upon in old age.

In addition, the participants’ responses showed that their aspirations in midlife were drawn from a continuous evaluation of their achievements from the past to the present stages. Thus, both the results of their behaviours in the past and the present were measured against certain expectations in midlife. They based this subjective judgement both on what they had accomplished up to that point and what they would go on to achieve in the future, thereby forming their identity. If the established standard endorsed by the society at large had not been achieved, the participants would view it as incompleteness in terms of them forming a personal identity.

In Chapter 5, the researcher will further discuss the factors that have contributed to ‘constructing self’, with the data suggesting that the population in this study identified their ‘selves’ as a collective entity. Their expectations for later life were about having mutual wishes in conjunction with their significant others, which were developed around accepted social norms. As a result, when the participants were exposed to certain situations, their intended behaviours seemed to be based on collective actions and were aligned with these accepted social norms.

Overall, the data in this study suggest that the participants struggled with ‘striving for reaching social norms’, in the mean of ‘securing meaningfulness’ and ‘disruptive health posed uncertainty in later life (see Figure 4-1).

#### **4.4.1.1 Sustaining socio-cultural values**

According to the participants, they perceived family values as being guided by practices passed down from generation to generation; as lessons learnt from friends and other members of the community. Thus, the data reveal that the values accorded to family are inseparable from the influence of social norms. The value given to the family was therefore not perceived independently but rather was combined with a social dynamic. For example, the participants' actions were shaped by the attitudes, beliefs and actions of other members of the society. Consequently, 'well-being' in old age was defined not as an individual accountability but rather as an aggregate of the actions taken by entire family units. As a result, unfulfilled expectations such as 'ageing with the expectation of filial obligation', 'sensing intergenerational disconnect', 'gaining social status' and 'becoming successful parents' became sources of profound stress for the participants. These affiliations of actions will be discussed in turn.

##### **4.4.1.1.1 Ageing with expectation of filial obligation**

According to the participants, a family that acts as a single support mechanism is an important factor that contributes to a good old age. Overall, three-quarters of the participants stated that, as parents, they could only potentially turn to their children for support. As a result, it was widely expected that the children's duties would include honouring, respecting and supporting their parents. Conversely, the other 25% of participants thought it would be a preeminent expectation of parents for the children to support them in their old age. However, to them, this tradition and ethic of filial piety had loosened, and they perceived that parents should become less dependent on their children taking care of them in later life. They viewed a continued dependence on their children as leading to considerable hardship and difficulty for them in later life. Thus, the older people would need to be prepared to be self-supporting and independent in order to avoid a stressful old age. Below is an example that outlines this claim:

*"In these days, we live a different lifestyle from our parents. Fewer children are taking care of their parents. The situation is changing; co-residence, that once was seen as an accountability of good children, is now becoming impractical. So, being independent is*

*important, but holding an expectation that the children will take care of us in old age might lead to frustration. It's because the children and their spouses are now working, and they have children to take care of too. But, I won't say that it has totally vanished from our society; unfortunately, it has become less. If someone expects that his children will take care of him in old age, he may end up with a stressful and worrying life if things don't turn out as he expected. So, better be practical than disappointed... Space has been created; the relationship between children and parents is not as close as in those days." – Selvam*

Nevertheless, the vast majority of the participants believed that only family members would provide unconditional care for their older parents; indeed, this was considered the norm. It was also perceived as an obligation and an unwritten agreement in which adult children or next of kin must play a prominent role in providing security in retirement, when necessary, in the form of income support, physical care and emotional support, without the parents having to ask for help.

*"My husband will visit his mother every weekend; he is concerned for her welfare. If his mother is sick, he will take care of her. ... Although my husband is old, he still takes care of his mother and gives money to her. But, when it comes to our turn, why does our son neglect us? I take care of mother-in-law; when she was sick, I brought her to the hospital. When I got a daughter in law, I was hoping she would be like me. But when I am sick, I am left alone in the house (cried)." – Kamsiah*

The above quotation from Participant Kamsiah highlights that the expectation for children to take care of older parents is an unwritten rule that has been expected and passed down through generations, and that there would seem to be an uncertain future created if this practice were to be abandoned by the children. The interview excerpt of Noor Anis below reemphasises the claim made by Kamsiah.

*"I took care of my mother when she was in the hospital. At that time, I was not sick yet. I took care of her from morning until night in the hospital. It must have given an example to my children. Back then, I took care of their grandmother, wouldn't they take care of me now when I'm sick? Now is the time for them to take care of me. Furthermore, I have seven children." – Noor Anis*

The children, therefore, are expected to observe this behaviour from the parents taking care of their grandparents and to do the same when they grow up. As a result, it is perceived as a failure on the part of both the parents and children if the children neglect

their parents' welfare or allow them live on their own. This feeling of not being good parents if the children disobey the custom of filial piety is clear in the quotes below:

*"...I asked my son what he saw? How his father gave him a good example...Meanwhile, we educate our children well. Give enough love...Why is my son not like my husband? Where did we go wrong?"– Kamsiah*

As highlighted in the above quote, children neglecting to care for their older parents would be regarded as a disgrace in the light of their parents' sacrifice. Likewise, the parents would be seen to have failed if they did not teach their children or educate them well. This type of situation was very clear in the data, with a memo written about one of participants providing an illustration:

*'He anticipated that in his old age he might also need a caregiver, just like his mother now. Therefore, the support from his children and family has been viewed as a crucial aspect for his ageing. He mentioned that his brother is lucky to have children who are obedient to him, not like his children. Now, he wished to grow old with his wife and wanted her to take care of him in his old age: "I could not imagine my old age without my wife, I even want to die before her.'* – memo of Maniam

Maniam, like many of the other participants, said that it was an established custom for children to take care of the elderly. The type of relationship mentioned between parents and children is the way in which families should function as part of this society. Moreover, the parents in this study mentioned that they had channelled all of their resources towards the children's welfare and, as such, the children would be their resource in later life.

*"I spent almost all my earnings for my children, for their education. I see their progress now. So, now it's their duty to help their parents if they remember our sacrifices."* – Firdaus

Family members were regarded as being responsible for each other's welfare.

*"...the problem of my siblings is like mine... My personal achievement always stands behind their needs. I would say that their well-being has become my responsibility; my mum and my elder sister are staying with me. So, I've spent rather my whole life taking care of them; not only both of them, the other siblings too."* – Analya

The above interview quote describes best the fact that the welfare of family is a collective task of its members. As a result, ageing without a carer from the family is seen as a profound risk of ageing, as mentioned by the following participants:

*"The risk of ageing is that there is nobody to take care of you. Somebody needs to look after you. What would happen if there was no one to take care of me? It's dreadful! My sister and I, who are looking after my mother now. My wife, who serves her needs, just imagine my mother's condition if there is no one there? It's children's duty to look after their parents."* – Maniam

As highlighted by Selvam, living together in an extended family environment helps older adult members of the family with a secure ageing.

*“My mother is staying with my sister now after my father died...having a family under a roof is important.” – Selvam*

Similarly, those participants who had no family (e.g. Single, divorced or childless couples) felt that they would be unlikely to get any support in the future and/or during negative life events. For example, the below participant, Analya, envisaged that her life in the future would be harder as she failed to keep herself in tune with the requirements of each phase of life, and, as a result, she was still single:

*‘She is a single female aged 41, who was living with her 70-year-old mother and her unmarried, 47-year-old sister. She said her reactions to the current situation were influenced by what she had learnt from society or by the way her family had taught her. According to her, she associated events she had encountered in the past and had learnt lessons from to minimise the risks that she anticipated in the future. By doing so, she thought that her later life could be secured. According to her, she had made poor plans in the past because of her insensitive attitude and had not paid attention to her surroundings. She now felt that she was living the consequences of those poor plans to stay single until now, and she needed to take an immediate step by having a family of her own. This would give her a better sense of support in her later life. She believed that society only pays respect to people based on their status and achievements. She intended to ensure that her activities were also worthy of earning the respect of society. She said: “Most likely, I won’t have a family of my own in the future. I’ve taken care of my family, but no one will be there for me in the future. So, I can foresee that my future being tougher than it might otherwise have been.’ – memo of Analya*

Comparing herself to her sister, Analya perceived her sister’s future well-being to be secure because she had a family of her own:

*“Well, she is not rich, but she has a beautiful family and children, so I think she is doing very well.” – Analya*

Similar to Analya, some of the participants in the study felt they had encountered more barriers or challenges in their lives compared to their friends or siblings who had

families. Therefore, for them, this condition was found to be disruptive and was identified as a great hindrance to the achievement of SA.

*“Having no kids is the only concern, we don’t know who will bury us? The question is how? Some said we could buy the cemetery lot beforehand. Yes, we can, but when the time comes, who is going to do it? There are only two of us left, so does the last one has to figure out a solution?” – Shiela*

*“In my family, I’m the only one who’s childless. So, my future is a bit risky! Because I’m single now! My niece insists that she’ll take care of me if anything bad happens to me. My family say they can look after me... I won’t know how my health will be in old age. I could be like my mother who needs help with feeding and toileting!” – Siti*

A few of the childless participants also pointed to the uncertainty regarding the support mechanisms that would be available to them in the future:

*“I don’t have children, so in the future surely we can’t rely on anyone. It is quite difficult for us; that is one of the main things. By having children, we can count on them to a certain degree. However, for us, it is unlikely to happen.” – Yong*

Kamaruzaman, on the other hand, shared his worry about a potential neglect of the ritual practice that his children must perform after he dies to ensure his soul is able to rest properly.

*“If I die, will my children pray for the peace of my soul? Will they visit my grave? My mind goes far, I don’t have the answer.” – Kamaruzaman*

For most of the participants in this study, the expectation around older age involved being with family members and having the security of their children to take care of them in the future. Any disruption to this expectation affects the security anticipated in later life.

#### **4.4.1.1.2 Sensing intergenerational disconnection**

In this study, the fundamental concept of SA for the participants involved ensuring there was an attachment with individuals with whom they shared an emotional bond, their children, spouse, extended family members or society would be seen as a key factor that contributed to a sense of ambiguity around whether they had support during

any crisis in the future. Therefore, the ‘family’ can be seen as a contributory factor in both good and difficult ageing.

Almost all of the participants with grown-up children had some level of disagreement with their children that arose out of intergenerational conflicts between ‘me now’ (e.g. Differences in values, knowledge and skills) and the ‘next generation’. These types of conflicts had a huge impact on the relationships and interactions between parents and their children. Most of the participants who had children felt that their relationships with them needed to be strengthened with immediate effect.

The participants considered that there were a number of reasons for a distance between the generations, with one participant, Karim, providing an example in the context of the advancement of technology:

*“Technology has advanced a lot. In those days, we watched movies in black and white, but now it has changed, right? The kids are highly knowledgeable regarding technology. Give a child a phone and look at how he operates it. So, I think the new generation and we are different in many aspects. Things like skills and knowledge level... maybe in those days technology was a preference, but now it has become a must... these have posed huge differences between the two generations, and it has become a challenge for us. In the older days, the children were different. Although naughty, they respected the elderly...Ourselves and the young generation should be friends; we should listen and discuss the problem together.” – Karim*

Another participant, Kamaruzaman, expressed his unhappiness with the conflict created by communication gap between himself and his children:

*“It’s a weakness, including my children who were using Facebook and other social media for saying bad things openly, right, things they never tell the world. The children may have a wrong perception. But have they ever thanked the parents for the things they bought for them? Never! But, when your children felt bad, while he isn’t thinking straight, everything has been written on Facebook. How could you not become smart enough to rationalise, openly criticise your family members to acquaintances, who know nothing? That’s the social media of the younger generation. As a parent, you feel sorry; it’s difficult. Probably it’s my fault that I did not raise my children properly; I failed to guide them to what is right. So, this is what I get in return.” – Kamaruzaman*

The advancement of new technology and social media, is therefore, was seen by some of the participants as a source of the distance created between parents and children. In particular, Kamaruzaman highlights the negative influence played by social media on the conventional communication with parents, which typically consists of personal face-to-face interaction.

Siti emphasised that middle-aged adults should have good communication skills and adjustment to the attitude of the younger generation needed to sustain a healthy relationship with their children or younger people:

*“One should adjust according to the situation. At this age, I behave to my age when I’m with the older people, while with the young people I can’t be the same. Meaning we should know how to communicate with the young people; it needs a different style of communication. I think we should follow the current trend. Young people must be tackled in a different way, although they don’t listen to us fully, a small change is still a change. We may have our style, but the children might dislike it. We have people in different standards. So, we have to follow their level. The old generation is a better follower than the children now. The children now connected with the social network, they know things that we don’t.”-Siti*

Some of the participants noted that when the younger generation displayed a hostile attitude towards older people to whom they were not related, they experienced a sense of ‘disconnect’ with the younger generation.

*“... The way they, the younger generation, look at us is killing us...For example, if you bring an older adult to eat in a café, just look around at the way the young people see them? They’ll look at how they eat, walk and sit. Eh, they see the older adult as though they have been transformed into a different person from the normality. So, tell me, where is the respect? The culture [of respect] hasn’t arrived there yet.”– Analya*

The negative attitude shown towards the older people by the larger younger generation highlighted by another participant below serves to illustrate the difference between his generation and the current generation.

*“The older people are having a tough time dealing with the younger people. The experiences in the shops and restaurants make me doubtful if we have the respect we need. You know, I might take the time to decide what I want or to walk, ahem, my mind is getting slower. But, the people around me are much faster than me. So, I*

*find lots of disagreement. In those days, we listen to older people without questioning them, but people now are different.” – Maniam*

Analya and Maniam both emphasised the ageism and subconscious stereotypes that the younger generation might hold towards older people as causing them (older adults) to sense disconnect with the younger generation. In addition, conflicting values and significant differences in expectations between parents and their children have become an important factor contributing to this sense of disconnect.

*“I bought a big house with five rooms. We bought it for them. My wife and I can live in a smaller house. Even before buying the house, we have envisaged that each room is for one of them; even after they married, they should stay with us under the same roof. But they did not agree to it. Their attitudes create a bad impression on me.” – Kamaruzaman*

It is evident from the data that there are contradicting values between the younger generation and middle-aged people in this study.

*“The older generation they are much disciplined. You hardly see them [the older generation] watching television for long hours. But the new generation can’t live without television.” – Shiela*

*“Although busy, the children should come and visit us. That should be the way; the children’s love will lessen our stress. Even, our (my) future will get better and healthier.” – Karim*

The above two participants highlight the variations in lifestyle between children and their parents. This difference serves to increase the loss of attachment between these two generations. In addition, the older’s lack of confidence regarding the maturity of young people in handling problems and making decisions by themselves has also contributed to the problem of loss of attachment between parents and their grown-up children.

*“Personally, I don’t like to get involved in their [children’s] matters, although they’re my children. Once they married, it’s their family. So, having a good relationship with the children means not to intrude in their family issues. They’re grown up, so [I] should treat them maturely. Let them work through their problems themselves.” – Karim*

Finally, the interdependent relationships between parents and children can also be a prime factor in the parents' sense of disconnect with their children. This was especially found to be the case when the parents were excessively reliant on the children and also when the children were seen as failing to live up to their parents' expectations. One retired participant expressed this concept clearly based on his personal experience and his learning developed through the observation of others.

*"The pressure is high for someone who becomes dependent on his children. If you look at this, it potentially leads to misery and a stressful old age. Some of my friends suffer depression due to having a greater dependency with their children, and the habit of intruding on their children's family life." – Karim*

The above participant perceived the potential for a stressful old age to arise not only from the possibility of them becoming dependent on their children for physical and financial support, but also from the attention that they, as parents and elderly, would come to demand as an expectation. The following excerpt from a participant highlights his fear that his children would not comply with his emotional expectations:

*"...for me, the love shown by the children is important in old age... The old folk need the children's love, attention and nothing else matters. However, it seems like I didn't get it! (Voice lowered)." – Kamaruzaman*

It was evident that relationship matters were the cause of the disconnection between the participants and their children and that they were also the source of some of the ambiguity with regard to their later life. As such, building support from family members in the present was perceived to be a priority for future security (see Chapter 5, Section 5.2.2). However, this study has no data revealing differing expectations between generations, such as the children's expectations of the relationship being different from those of their parents.

#### **4.4.1.1.3 Gaining social status**

A significant number of the participants felt pressured over their social status and the recognition gained from the wider community.

*"Truly, I don't think that older people are given the respect they should get. In fact, one's status is determined by their achievement,*

*like if you are a professor or holding an excellent post; not because that you are an elder!” – Analya*

*“People should respect us for who we are; I mean everybody: my wife, children, siblings and friends. It is very hard to achieve it, not easy.” – Kamaruzaman*

For some of the participants, such as those mentioned in the two quotes above, objective achievements become the measurement that society places on them and, as such, are the measures by which their success as a person is determined. Mostly, the participants’ social status in society, such as their occupation, education and position held, were mentioned as the measurements held by the society. However, the data show that these achievements are usually the collective results that are achieved by an individual in conjunction with significant others.

*“Life in the village is different; people there show respect because they have known my family and me for a long time. Some people even know my grandparents. That’s the tie that you want when you get old, and being valued and respected for who you are. This gives a boost... Even now, people recognise my father for his right attitude. He is a respectable person. Even now, our family is respected among the villagers...” – Selvam*

In the case of Selvam, his father is a successful businessman in the village and someone to whom the villagers will go for advice. Selvam further linked this scenario to the poor respect he sometimes received from the people in the city where he now lives, as they know him only as a lorry driver.

In addition, the present self-images of the participants were created from the past up to now, and they were seen as an impression that the society had of them. Due to this, many of the participants mentioned that it was hard for them to lift, repair or alter their past image into a new one in their current life due to the limited time they had between now and their old age. Consequently, in midlife, if the participants failed to secure an expected social status in society, this would exert pressure on many aspects of their lives and also create a negative image.

*“I never prepared financially... from the beginning, I didn’t see the importance of saving...I was working for the Department of Customs and Immigration, and you know it’s a job where you can earn money by wrong means. When my boss got to know about my*

*decadence I was sacked from work; my family isolated me [voice lowered] ... again I did another wrong move, ... I started a business with a friend. But, in 2005, he cheated me [pause]. Now, with me having health issues...eh, my time is limited, I don't think, so I'm able to change a lot of things. Maybe, I didn't remember him [God] [clearing throat]. ...Because, people say life begins at 40, but mine is like going downhill... looking at ten years from now is a bit scary!" – Firdaus*

Because of his failure to sustain a good career and due to a mistake, he committed at work as a result of which his morality was questioned, Firdaus's father and siblings cut ties with him. Referring to this issue, Firdaus indicated that he now has little time to change this image that people hold of him since he is suffering from a terminal health issue.

Overall, the female participants seemed to be less concerned about gaining social recognition through the specific type of 'achievements' that are associated with males (e.g. Employment, money). However, they were likely to identify their social status through the achievements of their families as a whole.

*"... When my children were all grown up and had good careers, my relatives looked up to me. You know, it is different from the way they looked at me in the old days. My eldest son is Mufti (religious leader); he has a high and respected position in society. It is quite natural for people to look up to you based on your position in society. When we have been placed well ourselves in terms of money and achievements, we are highly regarded... I do not want my children to face the same problem as I did if they do not get married and lead a single life." – Ayu*

Being a successful person in front of society influences the well-being of people, and the participants in this study have worked to create the identity of a 'successful person' in their middle age. However, this social status is a collective effort of the family rather than a personal gain. The participants in this study also highlighted that if this societal expectation of them is not fulfilled, it becomes a disruptive effect that might affect their well-being in later life.

#### **4.4.1.1.4 Becoming successful parents**

Additionally, in most cases, the participants expected their children to develop the qualities that were valued by society (e.g. Concern for their personal and material

advancement, social achievement and religious attainment). Many of the participants wished for their children to be their successors and to follow their example. In their view, being a successful parent was not only about having high-achieving children in a state of material attainment, but also about having children who would respect the traditional practice of filial piety (i.e. Treating parents with respect, fulfilling spiritual attainments, bringing honour to the family and seeking their elders' guidance (see Section 4.4). Having children with these qualities would dignify the participants in their successors. The following written memos from Participants Kamaruzaman and Maniam highlight the significance of having successful children for the people of this specific culture.

*'He is a retired civil servant who has won numerous laurels at work. He was born in a low-income family and was raised in the countryside. He is incredibly proud of who he is now and is in control of most elements in his life. However, he broke down soon after he had spoken about his failure as a parent. He revealed how he had deviated from what his parents had achieved regarding child rearing; they brought him and his siblings up to be well-educated and successful individuals. They had spiritual understanding and enjoyed good social status. He discussed his expectations of bringing his children up with similar qualities. He was struggling to set a good example to his descendants and expected that his life would be filled with similar successful stories, like those of his parents.'* -Memo of Kamaruzaman

Kamaruzaman seemed to struggle with his self-identity between being a successful person in his career (he obtained the highest recognition from the royal family for his contribution at work) and his children's failure in life (i.e. Being jobless, failing to finish school and experiencing marital failure). Moreover, his image of being an achiever changed overnight with the physical limitations imposed on him by a terminal illness. He was in tears when recounting, *"I entered the palace at the age of 35; I was the only lower-ranked officer ... Actually, my family should have been proud of me, but it didn't turn out that way."*

Below is a memo written by the researcher about Maniam. The interview with this participant seemed to endorse the issue that Kamaruzaman was experiencing with regard to being a successful parent.

*'He is a 51-year-old male, who is married and living with his family. He grew up in a middle-class family in a plantation estate before relocating with his family to the town (Johor Bahru) where he now lives and has a better job. According to him, he has close ties with both his immediate and extended family members. At times, he also felt regret over his children's life, whereby they were not progressing in the way he had expected. This issue with his children has impacted on his future and expectations of ageing. He also believed that the problems associated with his children have thrown him off balance and he gave this as the reason for all of his adverse health issues. He very much valued kinship and considered his children's achievement as the most important factor in his life.'* - Memo of Maniam

Both Kamaruzaman and Maniam further described the stress that they had suffered due to the bad image of the family's reputation created by their children:

*"I have four children, they are not that bad children, but they could have been better... My daughter has been divorced for two years now. The other son has got into the habit of borrowing money from people but never returning it. This has tarnished my family image. It upsets me and challenges my ageing. Until I questioned myself, 'why this is happening to me, when I never did those things to my parents?'... 'Look, they are going to be my heirs.' It is worrying me."* – Kamaruzaman

The data above also connect to the previous category of 'gaining social status', whereby 'becoming a successful parent' is also a social expectation held on a person's achievement in a collective manner.

*"... my children's behaviour affects me a lot because they're my top priority. I want my children to get married... My son is unemployed; ... These issues are disturbing. I feel that I have failed as a father. My cousin brother who is now 80 years old is still looking happy. I would say that he is fortunate to have well-behaved children. That's the main reason for his good old age. You know, when you see your children doing well, you'll automatically have the happiness you wanted. Almost everybody has a tough old age because of their children."* – Maniam

The above interview excerpt from Maniam highlights how the children's achievements in society become an important form of assessment in middle age and through later life. On the other hand, some of the participants described their achievement as being

related to the progress made by their children, which they viewed as being life course accountability:

*“We want our children to grow up to our expectations. But, if that doesn’t happen, it’s a failure on our part somehow. I think my responsibility towards my children will never get disconnected, ... I assume my responsibility will grow big as they [the children] grow old... However, I willingly take up the stress for the sake of their progress.” – Yusof*

Kamsiah also mentioned the parents’ responsibility for making their children successful.

*“When my son was in year one, my husband said to me, ‘Kamsiah (not real name), I want our children to excel higher than what I’d achieved’. We only finished high school. But we want our children to have a better achievement, so we planned their future.” – Kamsiah*

In the culture of Eastern society, when making decisions, children are expected to obey and seek advice from, or the opinions of, their elders as a way of showing them respect. In most situations, the children’s achievements were used as a yardstick for measuring parental success.

The three participants below – Firdaus, Karim and Ayu – mention their children’s achievements, and how these have positively influenced their well-being.

*“I’m proud of the way I have raised my kids. Praise to Allah Subaha Wa Ta’ala, ...my eldest is the girl, the second is the boy and I am proud of them. Although I might not know everything they do, to my knowledge, they respect their elders. My son, although only a diploma holder, he is a workaholic. He works part-time while studying at school.” – Firdaus*

*“Alhamdulillah, my children are doing well. So, I’m proud to see their advancement.” – Karim*

*“Allah blessed us! My eldest son is a Mufti (religious leader), well respected in the community. So I’m proud of him...– Ayu*

In a nutshell, the children were seen as a source of evaluation and a reflection of their parents in society. As a result, the parents felt it was a personal failure if they lost authority and emotional bonding with their children. In contrast, successful children

were seen as contributing to the better ageing of their parents. This challenging relationship between parents and children led to the anticipation of an unsecured later life.

#### **4.4.2 Securing meaningfulness**

Those participants who sensed a loss of meaningfulness in life appeared to have low resilience in the face of losses and deterioration. The sense of life being meaningful was observed to be higher among those participants who engaged in activities that helped to enhance their levels of self-satisfaction and self-esteem. The researcher observed participants who highlighted their participation in spiritual acts, community work and who were on good terms with those surrounding them, and these participants exuded greater positivity in life. Their involvement in these activities seemed to serve as a predictor of mental well-being. They were clear about what could be anticipated in later life. The following written memo from a participant identifies this element:

*'He is a 60-year-old male. He is married and has suffered heart disease since 2012. At present, he is living with his wife and adopted disabled child. Although his children are all settled and living by themselves, they still visit and support him emotionally. He seemed to be an optimistic person; I sensed that he was more attentive towards his future. We had a cheerful interview throughout. Having actively engaged in social work in the past and even at this age, he talked a lot about the connection that exists between oneself and the community. He identified isolation as a leading cause of mental distress in older people. He also pointed out that it could be largely eliminated if one were to actively engage in community work. He considered that the feeling of accomplishment achieved through participating in these activities contributed to emotional well-being.'* - Memo of Karim

According to the above participant, not being able to connect oneself to one's surroundings would lend a negative meaning to one's sense of self. He referred to some people he knew as doing great harm to themselves by being isolated from their surroundings after they retired.

*"If you isolate yourself, means that you're inviting stress to yourself...It is because of we, the older people are sensitive... I'm not lonely. I create [for] myself opportunities to socialise with*

*people. So far, it has given me an active lifestyle. Having money is not happiness. One will be happy looking at the smiling face of his wife, children or neighbours and relatives. Those people who stay alone in the house, I see them suffer emotionally... Through personal observation, people who have friends have a better life. My friends who are 'very old' [are] having an enjoyable life too..." – Karim*

He further highlighted how his own experience of being a Bilal<sup>2</sup> in a mosque allows him to be in touch with the community. He feels that the act of helping the community in need helps him to regain his vitality and sense of accomplishment.

*"Now, I have become a 'Bilal', and working as a 'Bilal' is a challenging task. For example, if there is a death in the village, I have to bath the deceased...After cleaning the body, I'll dress the body and then wrap it in a kafan (a clean piece of white cloth that covers the entire body). I don't feel that the job is a burden because I love it. The community is also like me, because I'm diligent, devoted and help others. They come to me because they have a problem and I'm happy that I have the opportunity to help them." – Karim*

In general, the participants reported that engaging in activities that made them feel meaningful and happy served to eliminate disruptive feelings (see Chapter 5, Section 5.2.2).

*"If I visit my village, I make sure I attend the religious class held in the village. Even here, I still go to [the] religious class, I've never missed it. In fact, I joined a choir group and [am] involved in charity work; I keep myself busy, so my mind doesn't linger around problems. And after retiring, firstly, I plan to go on 'Umrah' <sup>3</sup>..." – Siti*

Spirituality activities were seen as a means of balancing the gap between the components of well-being in later life due to disruptive events. A detailed discussion

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<sup>2</sup> A bilal is a person who helps an Imam in religious activities in a mosque. The bilal also assists the community in Islamic ritual activities such as those related to death and birth.

<sup>3</sup> The Umrah is an Islamic pilgrimage to Mecca.

of this aspect can be found in Chapter 5, Section 5.2. On the other hand, Shiela mentioned that she engaged herself with things that brought her happiness.

*“...why do people work hard to achieve certain things, then when they become old, they can't do what they like anymore? So, their achievements are meaningless. Most of us [are] in a mechanical life where we work hard and never spend quality time with our family members.” – Shiela*

She re-emphasised her idea of happiness using an analogy that happiness depends on how a person views it in relation to him or herself.

*“There is another story of: ‘The fishermen and a highly educated man. The fisherman's life is that he likes to go fishing, come back and drink, play the guitar and enjoy his life. But the other guy said, why you don't have a vision in life? With the extra money, you should buy a boat, and with the extra money you make, you can buy another bigger boat. Then you'll get more money, and then you'll be wealthy. Then, with all the wealth you can have an enjoyable life.’ The fisherman said, ‘I'm doing it right now (laughs). After you get so much money, I will still be doing the same.’ So, it is an individual thing about how you enjoy your life. So, the life is what you think, and how you handle it.” – Shiela*

Yusof mentioned the image he intends to project to society as a person who brings energy and happiness to others.

*“Some people say the positive aura you see in some people; you feel energised. Being a person that makes someone feel happy or generating an encouraging environment.” – Yusof*

Meaningfulness also depended on how people viewed others and their achievements. According to the two participants below, a common practice to compare what one has achieved with the achievements of others, such as their extended family members, friends and colleagues. However, this attitude, according to both of the participants, invites stress as no two persons' lives could be the same.

*“How you make yourself happy, is entirely your problem. So, my feeling is never [being] shaken. I never bother to know what people are up to. People say I'm 'stone hearted', but I can't follow what others do. Some people are very rich, can buy diamonds, but not everybody can have that life. So, I like to be myself; I only want to be happy every day. Nothing else I ask for!” – Mei Ling*

*“ ...my cousin who is also my age has a happier life. He is a millionaire. Not everyone can be like him; we can't compare our strength with that person. Moreover, I have chosen this way of living; he is doing business. To be fair to myself, as a government servant, how far could I have gone?” – Kamaruzaman*

Another element of meaningfulness for the participants was having autonomy in the family and being able to make decisions for themselves, with the family being viewed as part of their responsibility. In contrast, the female participants perceived autonomy not as self-oriented but rather as more of a collective action.

*“...my autonomy lies upon discussion with my husband and children. I can only make decisions after discussing with them, and I don't see that as less autonomy, it's just the way we do things.” – Ayu*

Participants such as Ayu and Kamsiah mentioned that decisions related to themselves and members of the family were taken after they had been discussed with the husband, who is apparently the leader in the house.

#### **4.4.3 Disrupting health**

The participants relate health as a source of losing meaningfulness in life. The overarching theme of ‘suffering the consequences of ill health’ was regarded as a second leading cause of a difficult old age, along with relationship issues. Nevertheless, those participants who were in good health also worried about the potential for their health to deteriorate in the future in the same way as they had witnessed in others known to them (e.g. Their parents and friends).

However, if their health assessments were good, this would lower their anticipated threats and worries for the future.

*“Since I am in the peak of health, I never worry about my health status in the future.” – Selvam*

*“People's life can be transformed overnight due to a health condition. So, the risk lies in the state of the problems that are encountered by a person.” – Analya*

The predictable consequences of ill health have been shown to include facing unexpected consequences of health issues such as a loss of productivity and financial

strength, becoming dependent and having limited lifespan. The consequences of the ill health experienced by the participants are detailed in the following sections.

#### **4.4.3.1 Facing unexpected consequences of ill health**

Life-threatening illnesses were seen as profound events that disrupt SA in many ways. The participants claimed that illness had altered their bodily strength, contributed to a loss of productivity, increased bodily discomfort and reduced their level of fitness over time. Life-threatening diseases such as heart issues, renal failure and other chronic illnesses were regarded as highly disruptive events.

*“For me, health is the top priority. If I’m healthy, I could do anything freely.” – Shiela*

Poor health status also led to sudden changes to the participants’ current lives and their plans for the future.

*“With my heart problem, I cannot climb even to the second floor without a break.... These days I just keep to the level of fitness and don’t force myself physically or mentally.” – Firdaus*

Most of the participants were afraid of immobility in the future caused by illness.

*“Stay healthy. Yes, must stay healthy. At 50 years old, I should still be able to work. What I see as the most important thing is the health, and that I am mobile. Some of the older people cannot walk or do anything. They just sit down all day and need people’s help for toileting and so on.” – Yong*

Equally, the prediction of losing control over advancing sickness created an uncertain future. Many of the unhealthy participants were living with an uncertainty of mind in terms of their potentially declining quality of life at a later stage.

*“... however, in the future, my body might turn me down. The future is uncertain; I have been on dialysis for more than ten years. So far, my body is still helping me, but I am weak already; ... having pain in all parts of my body. In a few years, I might be fragile.” – Noor Anis*

*“All I want is in the next five years to be like this, ‘if Allah permits me!’ My life in five years is unpredictable. I’m not sure; even now my health is already deteriorating. Imagine how I would be in 5*

*years. Most likely I'll be very ill, I'm just hoping that I can manage myself.*" – Ayu

*"Of course, the kind of tests you'll encounter when you are old and sick; they are emotionally disturbing. I'm hoping for good, couldn't be sure what lies underneath the future"* – Kamaruzaman

The participants also linked their past unhealthy habits to their experiencing of health issues in the present. Thus, some of the participants felt that making a change in the present might be pointless since positive changes should have been made before the damage occurred.

*"... The changes to the health status should be carried out from the beginning. I mean prevention is better; starting the repair work when we are at the old age will be difficult. I suppose the awareness that comes earlier will secure a better ageing."* – Karim

However, the majority of the participants wished to make an alteration to their lifestyle behaviours accordingly as a means of maintaining good health and preventing dependency in the future (see Chapter 5, Section 5.2.4).

Once they had begun to lose the physical ability to remain productive in the workplace, they began to fear the loss of their earning ability, especially when they were still in the phase of trying to bolster their financial capacity for the future. Moreover, financial capacity was important to them in terms of managing unexpected events, in particular for anyone who was suffering from a life-threatening illness that could lead to unexpected medical expenses.

*"I think the older you are, the more you are prone to fall sick. At that time, money is what you need. I could see the problem that one may face during old age would be money if one didn't prepare for it."* – Selvam

*"[That] I may lose the ability to work when I reach 50 years old is terrifying. I won't have an income, so I am worried about how to support my family."* – Salleh

Some of the research participants linked longevity to financial security:

*"... if you have the money, you could live for 100 years!"* – Maniam

*“I never prepared financially! I don’t have insurance. In 1985, when I started to work, I began with a luxury life... So, from the beginning, I didn’t see the importance of saving. Whatever I get, I finish it all, and never think of the future, and this is the cause of my suffering now.” – Firdaus*

In this study, financial security refers not only to hard cash in the form of savings, but also to the medical care and retirement plans implemented by the government. The issue of a medical care plan suitable for a good old age was voiced by one of the childless participants, Yong.

*“I think the Malaysian government should think of other things, like living standards and health care plans. I mean you still see a lot of older people with these issues. If the government deducts a certain amount from the people’s income for medical care, at least we don’t need to worry about the medical expenses in later life for terminal illness.” – Yong*

The above data highlight how individuals seek support from social policy when there is a change in the traditional family system that affects care in old age.

#### **4.4.3.1.1 Becoming dependent due to health issue**

The majority of the participants wished to lead an independent life, one in which they enjoyed physical strength and were able to move around and carry out their daily chores by themselves. However, for those participants who were chronically ill, their health issues were perceived as possibly pointing to impending immobilisation, and this led them to worry continuously about the future. As a result, this added fear to their old age, and they worried about getting help for their basic needs, especially at a time when they might be too frail, as mentioned by Karim:

*“I do not want to be “nyanyok” (senile) in the future. As long as I can move independently, and can do my basic needs without help from others, this is ageing well.” – Karim*

Ayu is wheelchair-bound and at the same time tries to be as independent as possible in the performance of her daily activities. She highlighted that the ability to move around independently enhances her overall well-being.

*“If I can, I don’t want to be a burden to others. Importantly, I should be able to do my work by myself. Sometimes, the doctor would ask me to be accompanied by someone, as I’m in the wheelchair. But I*

*don't want to disturb others. My children or... I just don't want to upset them (sounded very firm). If I'm able to do, I will. Even now, like this (referring to herself in a wheelchair), I stay alone whenever my husband is at an outstation. My children did invite me to their house, but I refused. I always find peace being in my house.” – Ayu*

The participants had developed an awareness of the consequences of being immobilised through watching their friends, family members and those around them who had similar health issues.

*“...being mobile is very important, ... once you are bedridden, that's it. Once you're in a disabled stage, everything is out of our hands.”  
– Shiela*

With the decline in their physical health, in addition to not being able to take care of themselves, many of the participants felt that they would become a burden to their next of kin. Almost everyone in this study stated that they would rather die than become bedridden, as they did not wish to become a burden on their family.

*“I am mobile now, but in the future, I might not be and may be bedridden. I wish to God that he will take me before it happens. That is much easier, nothing more to ask from him! The feeling of being a burden makes me feel miserable.” – Noor Anis*

*“If I can, I don't want to be a burden to others until my last breath.”  
– Ayu*

Becoming dependent on others also served as a signal of constraints on financial grounds:

*“I do not like to be dependent on others. Although I've children, I feel much relieved by being independent. I did not expect my children to take care of my wife and me or provide us with financial help every month, but they do help us when we have a shortage of money” – Karim*

Almost all of the participants wondered who would take care of them in the future when unexpected events occurred.

#### **4.4.3.1.2 Having limited lifespan**

Many of the chronically ill participants explicitly sensed that they had a limited time left to live. These feelings were triggered by the associations they had constructed

about old age, which had subsequently become reaffirmed in their minds by the deaths of others suffering from afflictions similar to their own.

*“I see it like this, one by one my friends passed away. So, I’m scared, right. Death is not what we want; it is God’s will. There’s a patient, who after she went through her dialysis one day, fell off from a chair and died. When I witnessed it, and we thought to ourselves hopefully that won’t happen to me. If God wants to take my life, I want it to be at home, what others say is a perfect death.” – Noor Anis*

The majority of the participants were afraid that they might not have sufficient time to complete their responsibilities. They felt that if they died, they would not be able to fulfil their duties and this would generate emotional pressures and financial concerns for the significant others who were looking after their care.

*“I also think my health issues aren’t recoverable. I think too much like how long I’ll survive. I think of my children; they’re small. But, ‘we are religious people, right?’ So, I pray for good things to happen.” – Salleh*

Although some of the participants mentioned that death could be unpredictable and sudden, for them, it was also foreseeable. They linked death to ill health and hence appreciated the quality of life and precious time that they were currently having.

*“Of course, we wouldn’t know when we’ll die; people die at a young age too. Therefore, when you are in the golden age, not only the age is gold, the time too. The grandchildren become gold, the people close to us: wife, siblings, they become very treasurable in our life. The time is precious to me...having five years is indeed precious for me. If only I could reach another five years, yes, anything could happen. We are humans, stunted. If God permits me another five years, it’s the most valuable gift of life. Err... if I were given five years, ten years or 15 years; that’s the equivalent of 50 years! But, maybe I could live up to another five years as mentioned earlier. In these periods, I’d hope for good things and pray that I won’t get tested with hard kind of stuff (pause – voice lowered), I meant to say that I hope to get better.” – Kamaruzaman*

Kamaruzaman above talked about the limited time he might have due to health issues and how much the present time becomes precious for creating good memories. Noor Anis accepted the fact that they may die at any time. Moreover, the death of other people with similar health conditions reaffirmed the participants’ feelings of being prepared to die or awaiting the call from God.

*“I don’t know my lifespan. If I could live up to my 60s, I’m blessed! But, some people suffer more than us. There is a young boy who died two days ago. I fed him a week ago, and now he is no more (voice softening). I liked the boy, saw him in the emergency department the other day; he was shivering. I told him he’d be all right, but the next day he passed away. He was too young. It doesn’t matter how old you are, if God wants to take us away with him, we have to go. It’s sad to watch the children who undergo dialysis session...I’ve suffered quite long and getting weaker now. I don’t want to make it hard on my kids. When I pray, I seek God ‘Allah my Lord, if you want to take my life, do it while I’m in the house’. It will be a proper death. I mean I don’t want to die in a miserable way or cause trouble to my children. Having this sickness, nothing is promising!” – Noor Anis*

Meil Ling on the other hand was a survivor and had been living on borrowed time since she had been on dialysis for a very long time.

*“I don’t want to think further. Ahh...because it is unbelievable that I could survive until now. When I got it, I was 45 years old, and I was in lots of pain. If I went a bit late to the hospital, the doctor said I might be dead by now. I didn’t feel anything at that time... Felt like I didn’t have any blood running through my body. My whole body was numb. The doctor said the toxin in my body went up. I thought that I would die. But, I was strong, though. I still remember that I asked God not to take me now. My children were small and told him to take me along with him when they’ve grown up. I couldn’t believe that I’ve survived 13 years already. So, now I don’t wish to live longer... I would be happy even if I die tomorrow!” – Mei Ling*

There was also a sense of the participants fighting against death and making the most of their remaining time. The resilience built against disruptive events is discussed further in Chapter 5 (see Section 5.2.1).

## **4.5 Key message**

The initial data pointed out that disruptive events underpin an uncertain situation and come on multiple levels, such as a personal prediction of a situation, problems of family members, surroundings and social pressures that require individuals to achieve certain fulfilments. Some of the disruptive issues faced by other people, which were predicted as potentially also happening to them also contributed to an ambiguous future. The findings presented in this chapter have demonstrated that social norms and health problems produce tension around the time of middle age that can disrupt successful ageing and can pose uncertainty for the future. Chapter 5 further discusses

the level of uncertainty and how the participants construct selves as a means of increasing their ability to cope in the face of uncertainty.

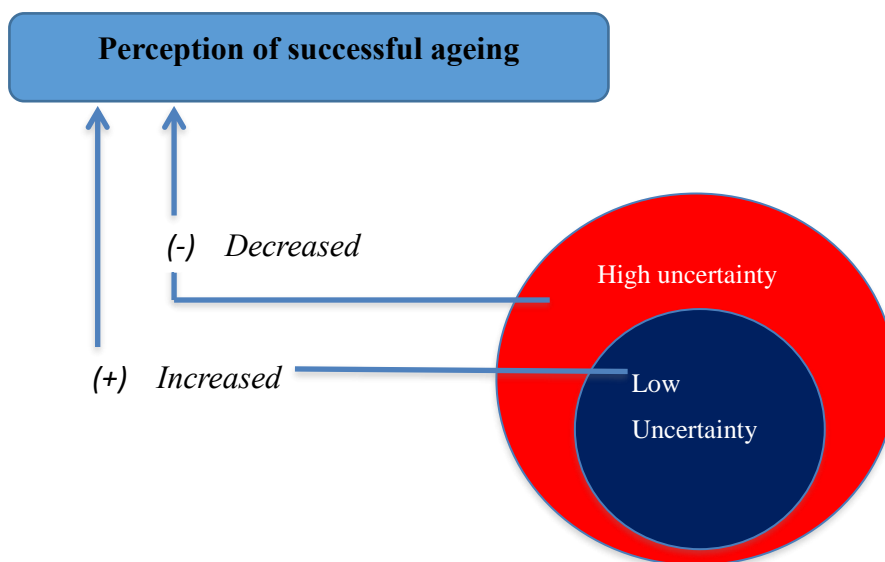


## Chapter 5 : Uncertainty, Coping Mechanism and Successful Ageing (SA)

This chapter reports further on the findings of the study. It first expands to look at the intensity and dimension of uncertainty and its association with ‘ageing successfully’. Next, it highlights the importance of managing uncertainty. Thirdly, it details how the participants increase their coping strategies with regard to the source of uncertainty identified in the previous chapter. It then presents four categories for managing uncertainty: ‘being resilient’, ‘building interdependence’, ‘creating balance’ and ‘modifying lifestyles and behaviours’ and sub-categories that outline the reactions projected by the research participants. Finally, it highlights timeline (short-term, middle-term and long-term) given by the research participants to the actions identified in relation to managing ambiguity in later life.

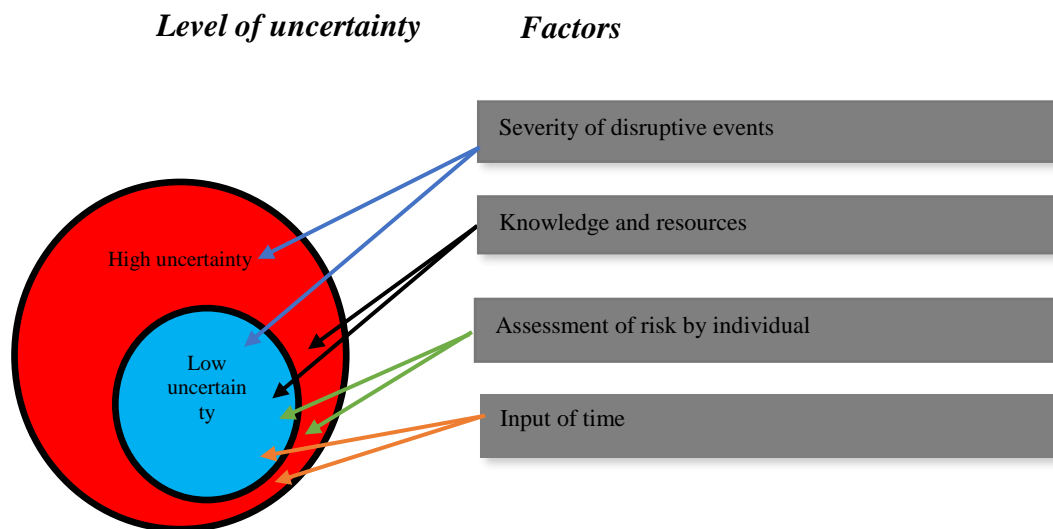
### 5.1 Dimension of uncertainty and successful ageing

The greater the degree of uncertainty experienced by the participants, the lower their expectation of well-being in later life. The diagram below that is part of the model at the end of this chapter which illustrates the link between the force of ‘uncertainty’ and the expectation of SA in this community:



**Figure 5-1: Force of uncertainty and expectation of Successful Ageing (SA)**

The priority given to the components of ‘contract self’ (see Section 5.2) in order to increase coping behaviours depend on the dimension of uncertainty, whether it is on the high or low scale. The dimension of uncertainty is influenced by the severity of the ‘disruptive events’, the knowledge and resources obtained, assessment of risks by individuals themselves and the time at which the narrative that the participants constructed from the situations that they experienced or believed would occur. When uncertainty in the future perceived high the intention for ageing successfully regarded low. Participants construct selves in face of adversity to cope with uncertainty perceived in the future through ‘being resilient’, ‘building interdependence’, ‘creating balance’ and ‘modifying lifestyle and behaviours’. The factors that influence the level of uncertainty are demonstrated in the figure below and discussed in the following section.



**Figure 5-2: The scale of uncertainty**

### 5.1.1 Severity of disruptive events

When ‘disruptive events’ are associated with extensive and profound effects in the future, the level of uncertainty anticipated also becomes greater. In other words, the awareness of uncertainty increases with the consequences of the ‘disruptive events’ and the risks that are calculated; the greater the risks anticipated, the greater the degree of uncertainty that is presumed.

I observed that there was greater uncertainty among those participants who perceived disruptive events to have brought severe consequences to their lives. In addition, the uncertainty sensed was greater if the consequences were unlikely to improve in the future since the outcomes could not be controlled.

So, when the participants were able to establish a relationship between situations with known consequences, the threats informed their actions and their level of uncertainty with regard to the future would be higher. For example, the level of uncertainty was higher among those participants who associated their health conditions more with further problems than with recovery and who expected an increased burden of disease in later life. Similarly, a greater uncertainty was sensed among the participants who had complicated relationships with their significant others that were never going to be settled, or among those participants who were likely to remain unmarried or alone for the remainder of their lives.

The beliefs held about adverse situations also influenced the participants’ perceptions of uncertainty. For example, most of the participants in this study regarded sickness as being part of old age. So, the uncertainty caused by health problems was not about having the sickness but by the level of support they may or may not receive when they fell sick (see Section 4.4.3). Khadtijah is a wife taking care of her husband who undergoes dialysis, and she mentioned that the support from the family helped her husband in dealing with his sickness.

*“Getting sickness is normal. For instance, my husband’s parents have diabetes. Probably it is in the genes since my husband was born. Hence, the family should be more supportive and have our backs, as we grow older.” – Khadtijah*

Therefore, the uncertainty surrounding the future was largely dependent on the intensity of the effects generated by the problem.

Drawing on two events experienced by a female participant on two separate occasions, I next discuss how she magnified the level of uncertainty that she faced. The participant in question was 50 years old. She discussed how her feelings of insecurity were driven by the worry of losing her attractiveness due to the menopause and old age and the effect that this may have on the relationship between herself and her husband:

*“I search on google about how people feel about menopause. What I read is mostly similar to my feelings! I have a strange feeling of travelling far away from everyone. Do my children still adore me? My husband, for example, does he still love me? Because I’m getting older, I’m probably not as attractive as I was before.” – Kamsiah*

With support from a family member, she came to feel in control. Therefore, she categorised her level of uncertainty to be low. She mentioned that to cope with this inevitable physical change, the support of family was vital:

*“I try to ignore the changes it brings; I know that I couldn’t entertain this feeling. But sometimes it has just got hard. Now, I see my husband tries to help me to deal with it. He said, ‘I know you are sometimes very moody. It’s very obvious! I can understand you. I want you to know that you’re a happy person, so I don’t want this mood to let you down’.” – Kamsiah*

However, her feelings of insecurity around being unattractive were intensified by an additional ‘disruptive event’ when she discovered that her husband had an extramarital affair with a colleague. This new disruptive situation had a greater impact on her relationship with her husband.

*“Ahhh.. Men always look for young women. Now, I’m no longer physically attractive, so my husband might have an affair? What if he leaves me and I stay single in the future? All these negative imaginations run into my mind.” – Kamsiah*

Thus, the uncertainty caused by her husband’s affair seemed to have had a greater impact on her later life:

*“Our life would not be happier always; sometimes God will test us on how we deal with the problems. My husband had an affair with someone...I’m in my 50s now; God has tested me (voice lowered). Hmm, how I could handle the situation calmly! I felt lost! I tried hard to face the problem calmly. Nobody next to me at that time, except my children. It was difficult to tell them about what happened. As much as I keep it to myself, I felt it was much harder. Often, I asked why God has given me such a big problem. I felt daunted (paused). God doesn’t give everybody a situation like this, so probably he wants to look at how I handle it.” – Kamsiah*

Subsequently, in her second interview, she mentioned that she had another worry that was caused by her eldest son, who had decided to move out of the family home with his wife. In this context, she was afraid that there would be no one to take care of her in the future.

*“My elder son had left the house with his wife. It was actually a little bit of.. I speak frankly uhh..., it had affected my husband and me as a mother too... When we are sick no one is there to care of us. My husband says if I fell sick, he would take care of me and if he fell sick, I need to take care of him...In hoping my son might come back I still tidy his room until got scolded by my husband. Because I cannot sleep at night thinking of it. My husband did not want me to go into depression.” – Kamsiah*

However, the uncertainty that was caused by the relationship problem with her husband was greater than the issue she was now facing with her eldest son. This is because she expects her younger son to stay with her in the future and has made some plans for her care support in the future.

*“When I am old, I believe my second son will take care of us.”*

The incident mentioned above also created uncertainty over who would perform the funeral customs when Kamsiah or her husband died. This is because a son is responsible for carrying out the last rituals when a parent die.

*“ ... at this time, we remember about death, we talk about it. For example, if my husband or I die, whoever is first to die, the first will perform the ritual. ‘You do not to worry about it, just pay to the funeral service in the hospital,’ I told my husband.” – Kamsiah*

In this case, she had an option. Therefore, the uncertainty anticipated was seen as manageable. However, if she did not have another option, the uncertainty might have

been greater. So, a problem that has a potential resolution may generate a lower level of ambiguity.

### 5.1.2 Knowledge and resources

The participants tended to make judgements that were based on conceivable and feasible assessments of the risks they faced in situations and the information they held. When they were unsure about possible lines of action, that gap in their knowledge created uncertainty.

*“I don’t want to have a bypass because I am worried about the impacts, I am also worried about the cost and age factor. I feel like since I am fifty years old, I don’t have to do this... I am certainly not sure what will happen to me.” – Firdaus*

The above participant also felt negative as a result of his thinking that something bad would happen to him after undergoing surgery, since he related his experience to those of others who had been in the same situation.

*“Feeling terrified, because people say men’s life starts in their 40s but I don’t see it. Almost given up myself last January when I was admitted to the Cardiothoracic Ward. The patients who went into ICU never came back. I didn’t see them after their operations. I know that ICU and CTW are different, but I don’t know what happened to them afterwards. What will happen to me? A few of them came out unconscious. ‘Why they were unconscious? Have they undergone surgery?’ I was aware that the blood vessel from my leg would be redirected to the narrowing valve, so that I might be in a wheelchair. Feeling so chill. ‘Will I be one of them? What will happen to me?’ So, I isolated myself from the others; I erased myself from WhatsApp. The conclusion is, I’m scared that my operation will fail because it involves the most important organ! ‘It’s a major operation, isn’t it?’ Now I’m waiting for June for a new operation date, which is the day of my death.” – Firdaus*

A ‘high’ level of uncertainty was perceived when the participants did not have any information regarding the potential outcome of the situation in the future.

*“After my heart bypass, I worry whether my children would take care of me or not, and financial matters as well.” – Firdaus*

*“But right now, I am unsure of my plans, due to my current health condition. Today, I depend on my kids as well as some of my savings for older age to pay for the treatment.” – Mei Ling*

Additionally, relevant information and resources about the ‘disruptive event’ related affect the confidence perceived by the participants.

*“Also, with having adequate resources, our confidence for the future can be increased. Such as the information we obtained through our experience all these years. I need information about the ways to overcome matters that worried us. Information such as what type of exercise should I do? How can I be better with my daily activity or how can I prevent my health from deteriorating further?” – Yusof*

*“At first, I had no clue about what to do when my husband told me about his illness. I knew neither how long he would live nor what was going to happen to my family.” – Khadtijah*

The input of time (see Section 5.1.4) seemed to be associated with the input of relevant information pertaining to the ‘disruptive events’ to minimise the level of uncertainty.

*“Having adequate resources, our confidence for the future can also be increased. For instance, the information we obtained all these years through our experience. Information about the way to overcome matters that worry us, such as ‘what type of exercise should I do? How can I get better with my daily activity or how do I prevent further deterioration to my health?’” – Yusof*

Particularly, the participants had gained more information about the ‘disruptive events’ and knew what to expect from the events that they experienced over that time.

*“At first, I had no clue what to do when my husband told me about his illness. I didn’t know how long he might live or what was going to happen to my family. Now, Alhamdulillah, it is not as difficult as it was. I now know how to take good care of my husband and am also ready to face problems involving his health condition in the future when they come.” – Khadtijah*

Therefore, relevant information and resources about the ‘disruptive event’ reduced the uncertainty caused by the problems

### **5.1.3 Assessment of risk by individual**

The data suggested that the majority of the participants developed uncertainty about the future based on their assessments about how things should be in later life. This means that if the assessment of risk expected from disruptive events is high therefore, the level of uncertainty posed is also regarded as high. In such cases, the same source

of uncertainty differs among different participants in term of the perception of its consequences.

For example, although, care from children became the main source of uncertainty and most of the participants felt sceptical as to whether their children would care for them or follow traditions and customs, different participants assessed the magnitude of the risk differently. For example, the perception of children being viewed as parental insurance was found more among parents who had concerns about their future security such as single parents or parents who may become dependent in the future due to health issues.

For example, Salleh mentioned the ambiguity surrounding his old age in the event that his children do not perform their responsibility to take care of him.

*“Can my children take care of me? (pause). They’ll be young, or would they neglect me as what I did to my late parents? Hopefully, they won’t!” – Salleh*

Similarly, Selvam on the other hand conveys substantial self-worry with regard to the projection of his life in the future without a life partner and support from his children.

*“... Getting old has been worrying since my wife passed away. No one is there to take care of my needs, but life must go on! So, my children are my pillars. Imagining my later life without them would be difficult.” – Selvam*

However, for participants who have good planning in financial and emotional terms do not see children as parental insurance, thus do not associate this situation with uncertainty in the later life.

*Although they (children) have no time to bring me to the hospital, but they are always very keen to know how I’m getting on (cried with joy).” – Ayu*

Therefore, the assessment of situations and its potential outcome by individuals suggest the magnitude of uncertainty perceived.

### 5.1.4 Input of Time

The data indicate that the input of time played a significant role in decreasing or increasing the level of uncertainty. It was noticed from the data that the length of time that had passed from when the participants constructed their narrative of disruptive events played a role in either decreasing or increasing the level of uncertainty. This was because some of the participants' uncertainty surrounding the future seemed to lessen, disappear or increase after some time when issues had been resolved or had been more complicated. For example, Firdaus mentioned the uncertainty he felt in relation to being reconciled with his parents and siblings, who had eschewed contact with him after his employer had sacked him for procuring money via inappropriate means. However, in the second interview, he mentioned that following the death of his mother, his other family members, including his father, had accepted him. Similarly, a female participant who experienced a relationship problem with her husband after he had an extramarital affair found some certainty after the problem was settled.

Below are two excerpts from participants with chronic illnesses, who explained how their level of uncertainty had changed over time:

*“There’s a relation between past events and uncertainties. But now I feel like the percentage of uncertainties has decreased.” – Firdaus*

*“Before falling sick, I did not think about health seriously. It never comes into my mind that one day I might suffer from a terminal illness. But it happened! When I first got to know about it, my mind was disordered, I did not see my way. It took me a very long time to understand exactly what was happening, what I should do for my future well-being. Whatever my future might be, my life is not going to be the same. But I am ready to accept it and make changes to my future targets. But it needs time; I need to give enough time for myself. With enough time given, we will develop confidence for our later life.” – Yusof*

The above data from Yusof highlights that the level of uncertainty will change according to the period of time. For Firdaus and Yusof, the level of uncertainty they faced at the time of disruptive events was high considering that the situations were new to them and they did not have adequate information about the consequences. The level of uncertainty, therefore, was certainly high at the beginning stage when the problems caused anxiety to the participants, insufficient information was available and

there were tremendous changes to comprehend. Although the uncertainty remained, they mentioned that its intensity had lessened as they had been in the situation for a while, which had enabled them to form some acceptance of the situation and obtain information about the consequences and how to manage it. Over time, once some stability has been achieved, they become more in control emotionally and there is more information and support available.

### **5.1.5 Importance of facing uncertainty**

Disruptive events were viewed as prominent factors that contributed to prolonged psychological turmoil and affected well-being in later life. In addition, the participants struggled to imagine their desired old age and this put them under enormous stress with regard to possible adverse situations and also led them to think of the unattainable aspects that were important to them.

*“Living a stress-free life is important, I see my friends suffer a lot. When you’re stressed, you’ll have a disturbed mind (your mind will be disturbed). Yes, when it involves your brain, you don’t sound right, you will lose your mind. The things that should not be done but [that] you will do without understanding the consequences. Because the pressure is so strong. That’s why when we are getting older; we have to free our mind. We need a peaceful life, thinking too much only leads to a stressful life.” – Karim*

*“...it’s the kind of test you encounter when you are old; sicknesses are emotionally disturbing.” – Kamaruzaman*

Planning for the future can be much more difficult due to this uncertainty. This led to some of the participants seeming to abandon analytical rigour in their planning processes.

*“Some of the unforeseen things that came along totally messed up our plans we had for future.” – Shiela*

Nevertheless, the uncertainty they sensed regarding the future led to anxiety for the participants. Consequently, the ability to manage uncertainty was noted as a crucial step in the present.

## **5.2 Constructing self to increase coping behaviours to manage uncertainty**

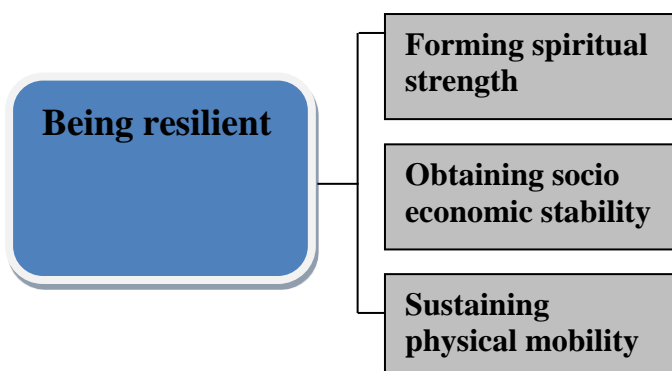
In the previous Chapter (see Chapter 4, Section 4.2.2), I have discussed how the participants reconstructed their selves based on the narratives of old age that occurred in midlife on a physical, cognitive and emotional level. These changes in their selves were realised in midlife; the participants reacted to uncertainty by finding meaning in their 'new' constructed selves. The participants of this study construct their selves through the development of coping strategies. The strategies taken help the participants to manage their emotional state by regulating their expressions of emotions, thoughts and actions to a situation relating to uncertainty. This understanding of the phenomenon focuses on four core categories alongside the associated factors of time (e.g. Uncertainty level changes with the input of time) and knowledge (e.g. The degree of uncertainty changes with the clarity of knowledge and skills), as outlined in the diagram below. Thus, the participants negotiated and reconstituted their selves into the changing contextual circumstances that create uncertainty in the future. These core categories are described in turn in the following sections.

<b>CONSTRUCTING SELVES TO MANAGE UNCERTAINTY</b>			
<b>Being resilient</b>  ○Forming spiritual strength ○Obtaining socio-economy stability ○Sustaining physical Mobility	<b>Building Interdependence</b>  ○Developing family connectedness ○Reaching out to community connectedness ○Seeking counsel	<b>Creating balance</b>	<b>Improving risk factors of deteriorating body</b>  ○Altering previous unhealthy behaviours ○ Initiating new behaviour for improving health

**Figure 5-3: Constructing self' as a way to manage uncertainty**

### 5.2.1 Being resilient

This first category describes the internal control that the participants need to possess and how they must be resilient and sustain mobility in order to do so (see Figure 5-4).



**Figure 5-4: Being resilient**

Internal control constitutes the foundation of emotional strength developed in the present for future personal growth. A male participant best described it as:

*“In old age, I need people to talk with; I don’t want to talk to the wall. But I have to prepare myself, eh, my emotions from now and for the worst too.” – Siti*

The data suggest that being resilient in the face of adverse events reduces the impact on mental well-being. Mental well-being seemed to be the key indicator for a good old age; three-quarters of the participants mentioned that having mental strength was important to prevent and protect against the anxiety caused by adversity and traumatic events. Two example quotations from Karim and Kamaruzaman are given below:

*“Stress will bring matters to deadlock. It might make you powerless... For me, even without money you still can be happy, which means you should not be lonely and lead a life of anxiety. When you’re stressed, you’ll have a disturbed mind. Yes, when it involves your brain, you don’t sound right... will lose your mind. The things that should not be done, sometimes you do without understanding the consequences. Because the pressure is so strong. That’s why when we get older; we have to free our mind. We need a peaceful life, thinking too much only leads to a stressful life.” – Karim*

Karim mentioned the impact of stress on mental health and the importance of having a healthy mind in older age.

*“... I’m mentally strong enough to face these issues with my children, and with my health condition, I needed to fight even harder. Once we enter older age, we become sensitive. It’s true. So emotional strength is important for good ageing.” – Kamaruzaman*

On the other hand, Kamaruzaman pointed out that older age can lead to an individual becoming emotionally vulnerable; therefore, being resilient will benefit old age by improving a person’s mental health.

A female participant, a wheelchair user who lived alone most of the time, also expressed a similar opinion:

*“When we are old and sick, we know our time is not long. We have limited time and can pass away anytime. So be vigilant about what we need to do. Be strong and fight against the illness. That is what is important.” – Ayu*

Mei Ling who had many difficulties in her life from working hard to establish her business when she was terminally ill and had been on dialysis for the past thirteen years, mentioned that being resilient helped her to face her situation effectively.

*“Having endurance is important. If you have an attitude of ‘being passive’, your life will be painful...so the spirit of fighting your condition is what is required for old age.” – Mei Ling*

Furthermore, this sub-category of ‘being resilient’ highlights the main ineffable quality of acquiring a positive mental state, which is derived through the formation of spiritual strength, obtaining socio-economic stability and sustaining physical mobility discussed in turn.

### **5.2.1.1 Forming spiritual strength**

Most of the participants perceived the formation of spiritual strength as an important element of well-being in old age. They closely linked old age with spiritual activity. According to the participants, spiritual attainment was seen as a common or natural act in older people (see Chapter 4, Section 4.2.2.1.3)

*“The Muslims especially will be seen in the mosque more often after becoming old. If I am blessed with a long life, I will be engaged in the religious activity, and that’s normally what people do when they become older.” – Yusof*

The period of middle age was underscored as the time for fulfilling this spiritual task, with awareness at this time of the difference between the desired state and its fulfilment to date. Many of the participants spoke of having a gap in terms of their spiritual attainment and that they should seek to close this gap prior to reaching old age. The two examples from both genders below explain well the importance of spiritual strength in managing disruptive events:

*“When you are working, you don’t have time for spiritual activities, and no time for church either. The period from being a teenager to 30 years or so, we tend to be reluctant, and then after that, we realise that we need to go to church... .” – Shiela*

*“As for now, I need to fill in the gaps. So far, I’ve visited the mosque less... I supposedly have to go to the mosque every day. In recent days, I have started to go to the mosque every morning.” – Kamaruzaman*

Importantly, in many cultures, especially in Eastern culture, life is regarded as being divided into two worlds: the present ‘temporal life’ and, after we have died, ‘life after death’.

*“In Islam, we have two worlds: one is here where we live, and the other is the world where we will be after our death. So, whatever we do here will be judged there. If we do not equip ourselves religiously, we have to answer later there, where our mouth will be sealed. So, only the body will answer, and it won’t lie... We will die one day. Therefore, the other world is more important than our current world that we’re in now.” – Noor Anis*

Old age is very much considered to be a period for practising spiritual activities, as highlighted by this participant below:

*“When we become older, we shouldn’t prioritise any other work more than religious practice. We should remember that it’s for now and the journey of our soul hereafter. About my current life, I am satisfied. Hence, I need to prepare for my afterlife. From the beginning, I have been thinking of the present life, so I have neglected the need for ‘akhirat’<sup>4</sup>.” – Noor Anis*

Therefore, spirituality was also seen as part of achieving self-actualisation and personal growth. Old age was looked upon as a period when material importance becomes less significant, but concentration on the afterlife is more important.

*“In our youth, we were less spiritual, but as I grow older, I think I’ve become more religious. That’s normal, as we, at this age, think about death and life after death.” – Khadtijah*

*“This is not the time for us to think about earning money; what I’ve earned so far is enough to support myself.” – Kamaruzaman*

As a result, the participants evaluated their progress of spiritual achievement in midlife so that action could be taken to address the gap in spiritual fulfilment prior to reaching old age. Pointedly, the participants related bridging the gap in spirituality with passing away.

*“I have to get myself closer to God, as I can die at any time.” – Kamaruzaman*

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<sup>4</sup> Ākhirat is an Islamic term referring to the afterlife.

This sense of impending death led the participants to realise that they needed to engage in religious practice and prepare for life after death.

*“I feel death is near, but I haven’t prepared myself fully in the spiritual dimension. The reason is that I was busy pursuing temporary gaining. At this age, I’ve come to realise it...hopefully, I will die in a good spiritual place. In Islam, only our good deeds will come with us when we die. Everything else stays here; our house, our titles and so on.” – Kamsiah*

The participants sought guidance from the Almighty over an unfortunate event or act, and in doing so believed they would become enlightened in terms of an unambiguous pathway:

*“Through God, I want myself to understand what is real and fake. I want God to be my underlying mind that tells me what I should do. Do you get what I mean? It is because our mind does not think enough. So, I should ask for God’s guidance that I need, such a clear mind until my last breath. Put aside the luxurious life; I just need a stable mind. Do you know when a person is lost? It is when he has lost his mind! So, what is so important? It’s our mind. Imagine that you have everything but can’t think what is good for you?” – Analya*

The participants associated spiritual attainment with an increased level of mental strength.

*“Getting connected with God will create inner strength... will give you the confidence to keep going forward.” – Yong*

*“I know I need to accept my feelings, do prayers and be involved in more religious activities so that my heart becomes lighter and calmer.” – Kamsiah*

Turning to spiritual understanding during adversity seemed to increase the participants’ mental strength, as discussed in the next section.

#### **5.2.1.1.1 Accepting adverse conditions – Al-Qadar, fate or karma**

A mind that is conditioned to accept downturns and is resistant to particular threats therefore counts as an asset in terms of helping to promote a good old age. Although health status has been ruled out as an important marker for sensing uncertainty in the future, at the same time it was also seen as a natural aspect when someone reached old age. Thus, declining health was no cause for alarm but rather was an outcome that was

expected with increasing age, and the participants should be ready to cope with the consequences. On that account, they felt that chronic health conditions such as diabetes and hypertension were signs or reminders of old age.

*“Changes in our health are a sign of time. Like me, I have heart disease.” – Karim*

*“... Having health problems is quite common when you get older.”  
– Maniam*

*“I go along with whatever happens.” – Yong*

Moreover, the participants believed that any difficulties or causalities were a condition given by God in order to test their willpower.

*“In Islam, we should accept the tests and be confident that we can get through the challenges. If you go into detail, it hurts (placed his finger on his chest), well that’s life. God wants to test my life. Maybe he might have something better for me later. If I don’t trust that way, its hurts”. – Kamaruzaman*

Therefore, the participants saw accepting an unfortunate situation and making sense of its purpose and occurrence as a way of ensuring lasting happiness and as a part of religious belief. The population in Malaysia includes three major races – Malay, Chinese and Indian – and each one has certain religious practices that are particular to each. Cultural attributes such as ‘al-Qadar’ (the divine will and decree) for Muslims and the acceptance of fate and karma by non-Muslims form the basic identity of the Malaysian population. These cultural attributes are also associated with their confidence when dealing with events that are considered ‘inevitable’ incidents.

*“God draws upon what has happened in our life, and we have to accept it. Allah has drawn fate upon us; we cannot avoid it. Look, even people who are not sick have similar problems as we do. So, we have to accept it. Acceptance of both negative and positive happening is part of life. Allah has given us our share, and we have to accept it.” – Ayu*

*“If it is fated then it is, as we cannot change our fate. Future is just a hope. So, go with the flow.” – Shiela*

Accepting a situation (most often adversity) was perceived as an emotional regulating mechanism: a belief that the struggles that one endures in the present may happen for positive reasons or because they are meant to be and thus no action could prevent them from occurring.

*“For me, faith and karma play an important role in facing my problems. I was involved in two accidents in a row in this week. So, I would say this was more than what I planned for; it is about the control of the Almighty. Something worse may happen, and I believe God must have saved me from that tragedy.” – Selvam*

Moreover, one participant highlighted that willingness to accept an adverse situation is not a weakness but rather the next step in finding ways to manage it.

*“Everything that happens has contributed to something positive and negative. We have to think positively and change our mindset. For example, I have to believe that my children will change and help me in old age. In Islam, we believe that something happens for a reason. We also have to work hard.” – Firdaus*

The ‘belief that an incident happens for a reason’ indicates a positive message behind it that improves participants’ emotional well-being.

*“We will find it more and more stressful if we cannot accept what is happening to us, no matter how difficult it is.” – Khadtijah*

For most of the participants, happiness was contingent on the acceptance of problems in life as their destiny, which had come to form part of their coping skills.

*“I never plan anything for the future because that gives me a lot of pressure. I follow the karma; I will totally face anything that is drawn upon me.” – Analya*

Kamsiah drew upon her experience of coping with the problems caused by her husband falling ill with a terminal health problem, and how she gained a fighting spirit by accepting the problem, as stated below:

*“We will become more and more stressed if we cannot accept of what is happening to us, no matter how difficult it is. I suffered a lot when he first felt sick, and one time I even thought of leaving him. However, I realised he’s my husband, and I had to be strong no matter what. When you accept your condition, Alhamdulillah, everything will be okay. If you can’t accept the events that have been*

*given by Allah, then you will feel dread when facing that hard reality.” – Khadtijah*

The data from Shiela re-emphasises the statement by Khadtijah above that ‘accepting’ a situation is an effective way of coping with problems.

*“When my mother passed away, I withdrew myself because my fate seemed to weaken. I said ‘why did this happen to me?’ But I realised that accepting what had happened in our life with courage would make us strong.” – Shiela*

In addition, the participants left their fates in the hand of God to decide their future, in the belief that God knew better what was happening in someone’s life.

*“I can’t talk about my future, as I don’t know how long I will survive. I leave it to God; if he wants to give me a long life, let him. Or if he wants to take me soon, I’m happy for that too.” – Noor Anis*

Being accepting of a situation was not perceived as surrendering to problems but rather as facing them and making an effort to resolve them:

*“We must believe in ourselves. We must have confidence in life to have the willingness to live. We must have a target in life even though we are old. We cannot leave it totally to fate. We must strive and believe that we will become healthy and that we can still be functional. We should not think that we are old and that is that. Even if we are sick, we have to work hard in finding the cure.” – Karim*

*“I know I need to be strong. I can’t give up as I might have the chance to live longer. Someone [else] who is in my shoes, she might have already given up. My husband is very sick too. Three weeks ago, he was admitted to the emergency, I said ..., ‘I’d let him go (die)’ because I didn’t want him to suffer. But he didn’t.” – Mei Ling*

The data above show that the attitude of ‘accepting’ is not means of ‘surrendering’ to the problem; instead, it is a step to a higher level, in which a person will look for solutions to the issues.

### **5.2.1.2 Obtaining socio economic stability**

Their surrounding environment also influenced the participants’ resilience. A positive environment and society played an important role in instilling a spirit of fighting against adverse events.

In addition, a supportive society encouraged a sense of togetherness in coping with intensely painful emotions.

*“I think having a helping neighbourhood is important to get us focus ... And understand our power.” – Firdaus*

The strength they drew from their surroundings and collaborative actions gave individuals the added capacity of being able to better anticipate change and influence their future behaviour.

*“If somebody pressures us on healthy eating, we might eat sensibly. We eat simple food, but because we eat street or fast food, mostly fried food like KFC. Every time, at least every week, we’ll eat fried chicken and fried food.” – Shiela*

A positive environment within a supportive neighbourhood was seen to promote good ageing. The social relationship of care and the respect of elders in public were also mentioned as important factors for increasing longevity.

*“Supportive elements will encourage us to live longer ... if people look at us negatively that will push us towards nothing but to die soon.” – Analya*

*“My plan for old age is to move to the village... I don’t want to suffer my old age with physical pain or mental exhaustion. I will feel comfortable growing old in the village compared to being here.” – Selvam*

The social encouragement and care received from the neighbourhood and community were regarded as ways of increasing the sense of belonging and reducing isolation.

*“The Malays, we often have social gatherings, and the older people often attend them. That’s the practice among Malays which helps to maintain good communication with our neighbours.” – Yusof*

*“My neighbours would always visit me, and if I was silent, they would come to my house and ask: ‘Ayu, what are you up to, why are you so quiet?’ Although many times I was alone in the house, I never felt lonely every time I came back after doing dialysis, my neighbours sent me food, knowing that I would be very exhausted and could not cook. So, my mind will not go numb because I have friends around me.” – Ayu*

For an individual such as Ayu above, having to fight a terminal illness might easily isolate her from the social world due to the immobility caused by her health condition. Therefore, having an encouraging neighbourhood will motivate her to keep fighting the predicaments associated with her physical health.

Besides a supportive environment, material security was the other most important extrinsic factor for resilience. Half of the participants mentioned that doing well in material terms was a prime asset for a good old age. Sustained independence in older age was associated with financial security to support the ‘unforeseeable’ future owing to disruptive events.

Therefore, financial security was seen as an important resource for managing the unexpected events that may be thrown up by old age, especially in situations in which an individual’s health has deteriorated.

*“I may lose the ability to work in my 50s, and that is terrifying. I won’t have an income, so I am worried about how I will support my family” – Salleh*

Additionally, a financial crisis erodes the fighting spirit, especially for adults suffering from a life-threatening illness. Two meaningful excerpts from the participants below further describe the situation mentioned above.

*“I have to deal with my chronic illness and the financial issue at the same time ... If we fall ill, we cannot work. But at the same time, we need money for the treatment.” – Mei Ling*

*“I need to have earnings to take care of my medical expenses, but I cannot work .... When we have a health issue, our views about later life may be different from those of normal people. When an unexpected situation haunted us, our plans for the future change.” – Shiela*

Equally, the healthy participants mentioned the need to save money in the present in order to reduce the risk of a financial deficit in the future. Therefore, middle age was perceived as the time for saving money, since they were still healthy and productive. Most felt that their productive age had shortened and that old age was approaching.

*“I think the older you are, the more likely you are to get sick. At that time, money is what you need. I can see a problem that one may face during old age would be having inadequate money if you haven’t prepared yourself for it.” – Selvam*

Having adequate savings for the future linked to a satisfactory, happy and healthy old life was seen as contributing to longevity.

*“... if you have money, you could live until 100 years!” – Maniam*

In this study, the financial security mentioned was not only about having money savings, it was also about the medical care and retirement plans imposed by the government. One of the childless participants below best described financial functioning from an angle of socio-economic security:

*“I think the Malaysian government should probably think of other things like living standard and medical care plan. I mean you can still see many older people with these issues. If the government deducts a certain amount from the people’s income for medical care, at least we don’t need to worry about the medical expenses for terminal illness in later life.” – Yong*

The participant below highlighted financial security in older age in terms of commodity and insurance investments.

*“... I bought insurance, car and then my house. Now, I’ve rented out the house for extra income.” – Shiela*

Achieving financial security in older age was most highlighted by the childless participants with existing health issues and no carer, who potentially faced greater risk in the future.

### **5.2.1.3 Sustaining physical mobility**

Besides being resilient, sustained physical mobility was also viewed as being important in old age in order to support the ‘unforeseeable’ future owing to disruptive events. Sustaining mobility was also associated with financial security, as mentioned in the previous section (see Section 5.2. 1..2), as a means of support in an ‘unforeseeable’ future owing to disruptive events.

Although the participants viewed old age as being a time of interdependent with others, a majority of them envisaged independence in terms of physical mobility as the main factor in SA (see Chapter 4 and Section 4.4.3). The most important aspect associated with ‘sustaining independence’ was having good health. Therefore, most of the participants mentioned improving their health to sustain mobility and not being dependent on others for daily chores.

*“What I see as the most important thing is my health and being mobile. Some of them can’t walk or do anything. They just sit down all day and require assistance for toileting and so on.” – Yong*

*“I want to be independent; iron my clothes, wash my dishes and cook for myself. So, I have to make sure I can still move around in the future by improving my health now as a priority task.” – Noor Anis*

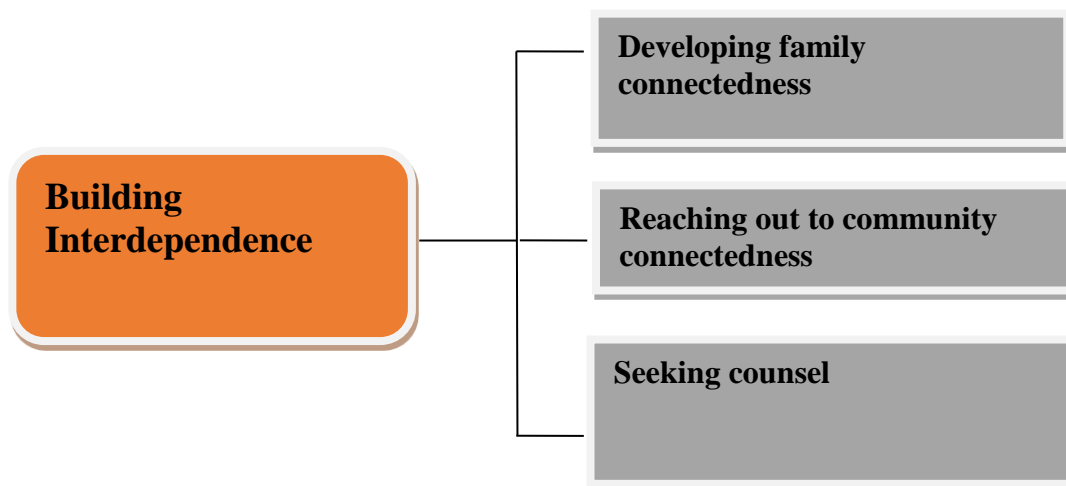
Regardless of their condition, both the healthy and unhealthy participants wished to be self-supporting and be able to count on their physical strength without the help of others.

*“My friend already has plans for her old age. She is now in her 50s, and if she is bedridden, she does not want to carry on with her life and become a burden to her siblings. That is also part of the process: it depends on what you are going through. If I were bedridden, it would also be the time for me to go off. It’s better than being a burden to others and as long as I can walk without any aid. Some people need others’ help to move around to prevent falling. So, if I can, I want to be healthy.” – Shiela*

Many of the participants, as mentioned Shiela, disliked the prospect of being in a situation where they would have to depend on others for personal assistance because of their frailty (e.g. Being incontinent or bedridden).

## 5.2.2 Building interdependence

This second core category of ‘building interdependence’ covers the aspects of developing family connectedness, reaching out to the community and seeking counsel in a time of need (see Figure 5-5).



**Figure 5-5: Building interdependence**

the data that is inclusive of family and community connectedness in reshaping one’s identity and seeking counsel.

### 5.2.2.1 Developing family connectedness

According to the participants, the family is an important supportive element and connectedness with family members highly expected to reduce the impact of uncertainty.

#### 5.2.2.1.1 Building good relationships with significant others

As outlined in the previous chapter, issues with family members were perceived as potentially contributing to a vague future relating to the caregiver, becoming successful parents, etc. Moreover, in this community, family members are expected to be responsible for taking care of each other’s well-being, as mentioned by Analya:

*“Imagine if you have a family: husband and children. If anything went wrong in the relationship, would you think about your future?”*  
– Analya

Family issues seemed to highlight profound issues relating to a dark future for some of the participants.

*“We [referring to older people, including himself] are sensitive and need assistance from the children. Well, if you ask me, it makes much difference. At my age, most vulnerable of all is the heart. Every day I pray for fewer challenges from things that may give us grief and hurt our feelings.” – Kamaruzaman*

This was because family members were the people with whom they shared not only their values and experiences but also their achievements and failures. For instance, the participants seemed to blame and condemn themselves if they failed to accomplish the task of parenthood or if their child had not performed well or achieved outstanding results. Thus, the representation of self in the participants was linked subjectively to the achievements of significant others (e.g. Their children or immediate family members). In line with collectivist criteria, the success of a person from an Asian background is frequently measured beyond the involvement of the self. For example, among the Asian population, one’s success is widely determined by the collective achievement and social recognition gained by the family members rather than by an individual’s own accomplishments (see Chapter 4, Section 4.4.1.1.3).

As a result, in the studied population, ‘self’ is defined with reference to significant others. So, when the participants were asked ‘what makes better ageing?’, the majority stated that having support from their family was indispensable. All of the married participants with children stated clearly that having close relationships with their children would establish good ageing. This interdependent relationship was regarded as a healthy and positive way of growing old in this community.

*“I don’t have problems with my family and also do not foresee any problems in the future. I think family members are pillars of our emotions.” – Ayu*

The participants negotiated their expectations of a harmonious relationship with their families. To them, this would increase their level of security, particularly with regard to emotional and material support in later life.

*“We told our kids about their father who has a serious illness at the moment. Without a doubt, family plays an important part when it*

*comes to the best decision-making. We had a family discussion and the children helped me to get rid of the uncertainties with their good responses.” – Khadtijah*

On the contrary, the absence of a good bond with their children or close kinship appeared to act as a warning sign of an unhappy future. As mentioned in Chapter 4, relationship issues have become the biggest challenge in the present and have created uncertainty in terms of the ability to achieve a good old age (see Section 4.4.1.1). All of the participants who were on good terms with or who had conflicted relationships with others who were significant in their lives highlighted that a consistent effort to reconcile disparities or to sustain the bond with their children was a central action for the present. As a result, most of the participants mentioned that they were moving towards greater tolerance in their lives at present in order to promote harmonious relationships with family members.

A male widower mentioned that the unity displayed between his late father and his siblings was a motivation for maintaining the family harmony.

*“...All my life, I can't remember a day that I quarrelled with my mother. As I told you, 'I will never fight with anyone'. I need my family and find the happiness through them. Their presence in family occasions is important.” – Selvam*

This type of protective relationship was mutually accepted and positively expressed between parents and children.

*“...I feel that they (the children) play a major role in my life now and forever. They must support me emotionally and physically. I wish for them to succeed in life and take care of me in my old age. .... My children are my pillars. Imagining my later life without them would be difficult.” – Maniam*

The parents, on the other hand, sensed that their responsibility towards their children continued even after the children had become adults.

*“My family means so much in my old age. Even now, I still phone my children to find out about their well-being, although they have married .... My husband and I expect them to do well and remember us in our old age.” – Khadtijah*

The participants expressed a strong preference for their family members to take care of them in their time of need. This kind of protection and safety net had come to be regarded as a traditional way of reducing uncertainty about the future.

*“Why should we find it difficult even among family members to have a harmonious relationship? Why should we have bitter feelings?... Importantly, I want to see that my children are fine; my grandchildren are good and no fighting among them. .... At this time of having a life-threatening disease, I really hope that I could build a close relationship and better family atmosphere.” – Kamaruzaman*

With respect to the dependency system built between family members, some of the participants mentioned being tolerant with them to avoid disputes between family members.

*“... I didn't like to heat up the conversation with family members which may potentially end up with a dispute and that we may not be on talking terms. This had happened in my brother's case which harmed the relationship between us. Sincerely, I do not wish to have any problem with them and want to keep the unity in the family.” – Selvam*

Similar to Selvam above, Noor Anis also mentioned being flexible with her family members and husband in certain situations that demanded her involvement.

#### **5.2.2.1.2 Building interdependence on family**

Ageing without a caregiver, especially when the participants become frail, increase their uncertainty regarding the future (see Chapter 4, Section 4.4.1.1.1). It included making some adjustments (see Section 5.2.2.1) to their expectations of being on good terms with or maintaining good relationship with others. These adjustments were to ensure that the participants would have someone to look after them in their old age, especially when it became difficult for them to carry out their daily activities.

*“I can't let them be upset with me. Patience is important, fighting with each other is risking later life...I must be good to people, because in the future I might need their help! When I'm very old and fragile, people will remember how I treated them. For a better ageing, I need to be good to my children. So, when I suffer from health issues, they'll look after me. I need to be nice with everybody in the family, including my spouse.” – Noor Anis*

Kamsiah's son had decided to move out and live separately, which caused her a great deal of uncertainty in terms of finding a caregiver for the future (see Section 5.1.1). Eventually, she came to the realisation that her children may not look after herself and her husband, and she had therefore made different plans, as stated below:

*“Sometimes we change our decisions... when we (she and husband) are old; we will take care of ourselves. We want to bring our brother to live with us. I've got a brother and sister who are single. Even my husband's sister who also did not get married. They can take care of us in old age, and in return, we will give them a roof over their heads.” –Kamsiah*

Similarly, other participants mentioned that the children had once been the conventional caregivers of older people in their family, while also observing that this practice appeared to be adopted less in the modern day. As a result, the participants mentioned that they relied upon their other family members to take care of them.

*“If anything happens, and if my children are not with me, I know that my family members will help or at least I can ask for their help. It is always better to rely on people who are next of kin ....” – Maniam*

Being unsure of who would act as a carer was highlighted as an important ambiguity associated with old age, especially for a single person.

*“My niece insists that she'll take care of me if anything bad happens to me. This is the main reason why I would like to attach myself to a charity association after retiring. So that if my health became worse, I would know how to deal with it. My intention is to serve people but at the same time to make contacts that would benefit me. Because I'm single now! My family say that they can look after me, but that may not be the case in actual situation.” – Siti*

As Siti states above, she attempted to align herself with a non-profit organisation for the same reason. In so doing, she believed she could find someone who could potentially help to take care of her in her 'very' old age.

### **5.2.2.2 Reaching out to community connectedness**

The participants used the act of reaching out to the community as a diversion from the emotional turbulence and as a way of managing uncertainty.

Engagement in voluntary work and the link to successful ageing has long been studied. In this study, engaging in voluntary work was related to better mental health and is regarded as a factor contributing to self-fulfilment.

*“Actively involve oneself with charity work, I think that is the best thing to do right now. Connecting yourself to your inner soul.” – Kamaruzaman*

Engaging in social work is another way of enhancing emotional well-being in older age, at a time when some individuals might have decreasing ties with family members.

*“if the children didn’t support us emotionally..., the best choice is to come out. We can’t lock ourselves in the house, that won’t create happiness. Come out from the house and look around! I think loneliness is what brings the negative elements into us.... Through my observation, people who have friends usually have a better life. My friends who are ‘very old’ are having an enjoyable life too. I could tell you that those people who prefer to stay home and spend time alone will get depressed. My friends who are very old and are actively engage in society work. I can see them smiling all the time and have never seen them restless, and that I think is the best old age.” – Karim*

However, volunteering work was not a way of ensuring well-being for every participant, especially for the female participants, who seemed to talk less about it. Some of the male participants indicated that voluntary work would be the best option for good ageing and for someone who is passionate about it.

*“Thinking of doing charity work; giving back to the community will make me happy. Volunteering will keep me going because I just love it.” – Shiela*

Many of the participants with grown-up children felt that their loneliness was due to an empty house after their children had got married, or otherwise it was due to a lack of communication with their children. As a result, the social encouragement and care received from the neighbourhood and community were regarded as a way of increasing their sense of belonging and reducing isolation.

*“... we have to make a lot of friends..ah, when you have good friends around, your heart becomes lighter. Right? If you have so much money but no friends, your life will become meaningless, isn’t it? If someone sits in the house, doing nothing and reading newspaper, this to me seems like a bad idea. So look out for friends.” – Karim*

Old age is the time when a person potentially ends their productive period (e.g. Being physically incapable, weak or retired) (see Chapter 4. Sections 4.2.2). This was very pertinent to the male participants, especially after retirement, once they had lost an active role in society and family. In such situations, engagement in community work was perceived as a substitute that made up for this change in personal identity.

*“The house is now becoming an empty nest..., when the children reach adulthood; they will have their own family and move on ... We started as two...a couple, right? We’ll be back to two again. If I am not involved in the community work, it would be a devastating experience.” – Karim*

In addition, participating in community work helped to keep the participants active after retirement and sustain their cognitive power. Participant Siti, who is a divorcee, required some continuity of her self-identity as an independent working person after retirement. As such, she mentioned that joining an NGO related to her working environment would serve the purpose.

*“Actually, after retiring, I would like to join an NGO... when I am alone, my mind would start to wonder about things that are completely rubbish.” – Siti*

The data above demonstrate how social work has the potential for sustaining the identity of certain people in the community as they age. Voluntary work has been linked to preventing isolation among older adults due to the change in their social network during later life. However, the data show that engagement in voluntary work is not the preference of most of the participants in this study (see Section 5.2.2.2).

### **5.2.2.3 Seeking counsel**

Listening to certain people who were regarded as referents in society seemed to provide guidance during difficult times.

*“... I think it is important to listen to wise people. You know, people with wisdom. At the workplace, I have a colleague. He is not highly educated but loves to read. So, we often discuss the matters that he should read stories like Ramayana and Mahabharata. I love to listen to him as I come to a lot of consciousness from discussion of the stories.” – Selvam*

Religious preachers (e.g. A religious leader, mufti<sup>5</sup>, Imam<sup>6</sup>) were cited as referents in society and were respected as people who are knowledgeable.

*“Alhamdulillah, many of my relatives are becoming clerics and Imams. So, I always get in touch with them. ...in all our family weddings and gatherings, we include religious talk. Soon after I retire, my sister and my uncle will retire too. So, we plan to have a religious talk arranged especially for the family members....when I visit my village, I make sure to attend the religious class held in the village. Here, I still go to religious class, never missed it.” – Siti*

Apart from specific referents in society, the participants also sought opinions and guidance from their friends or other individuals who could help them deal with their issues and ambiguity.

*“I think we who are aged between 50 and 60 cannot keep ourselves isolated. We have to mingle with wise people surrounding us, talk to them and get their opinions on issues. Or get their experiences for a better future. So, we can be more relaxed, and that we will wake up with a peaceful mind every day.” – Karim*

The wise people highlighted by the participants are people who they believe to have experience in certain aspects of life and/or who possess greater knowledge, such as in religious practice. The participants reach out to these people to obtain advice or guidance from either the ‘wise people’s’ personal perspective or from the perspective of religion.

### **5.2.3 Creating balance**

This third core category is about creating a balance as one of the components (e.g. Family support, financial condition) of a good old age. In Section 5.2.1, the data suggested that inner balance is an important requirement for well-being in later life. For example, the participants talked about the relationships that would need to be right and also how their support or potential support would have to be in place. Additionally, spiritual knowledge should be well acquired and their health would need to be good.

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<sup>5</sup> A mufti is a legal adviser on Islamic religious matters.

<sup>6</sup> An Imam leads Islamic worship services in the mosque.

Ideally, all of these components of ageing successfully in later life should fit together like the pieces of a jigsaw, with every part having its own proportion. If one of the elements should become smaller, the others should adjust in order to re-establish a proper balance. For example, if the health component should worsen, the support component would need to increase to compensate. If the support from children is reduced, then financial strength must be increased. In a situation where death is sensed as getting nearer, the participants seemed to analyse their fulfilment of the spiritual requirement. As a result, the proportions of religious activities increased as a way of obtaining guidance and purpose in life, thus resulting in improved well-being. The following participants, Analya and Khadtijah, expressed their views about ‘making balance’ with the relationship issue by expanding the focus to spiritual activity.

*“Now, I have been moving towards spirituality because it gives me peace of mind.” – Analya*

*“When I become upset, I recite ‘zikir’<sup>7</sup>. This helps me to have a peaceful mind. Having a peaceful mind is important so that I can be more patient and make better decisions, especially when dealing with my husband’s illness.” –Khadtijah*

It seems to be part of the social beliefs and cultural norms that the practice of securing a balance between the components of well-being should increase the sense of certainty for the future. For example, health was seen as an outcome of old age. Therefore, it was regarded as a condition that was caused by fate or a test from God which one would need to endure (see Section 5.2.1.1.1). As such, for the unhealthy participants, other elements besides health also needed to be included to balance the equation. This meant that in order to deal with situations that were beyond the participants’ control (e.g. Ill health), there would need to be a corresponding substitution with the other sections of the jigsaw, which can be stretched and balanced to reduce the ambiguity generated by the conditions that were unavoidable. As a result, when the component

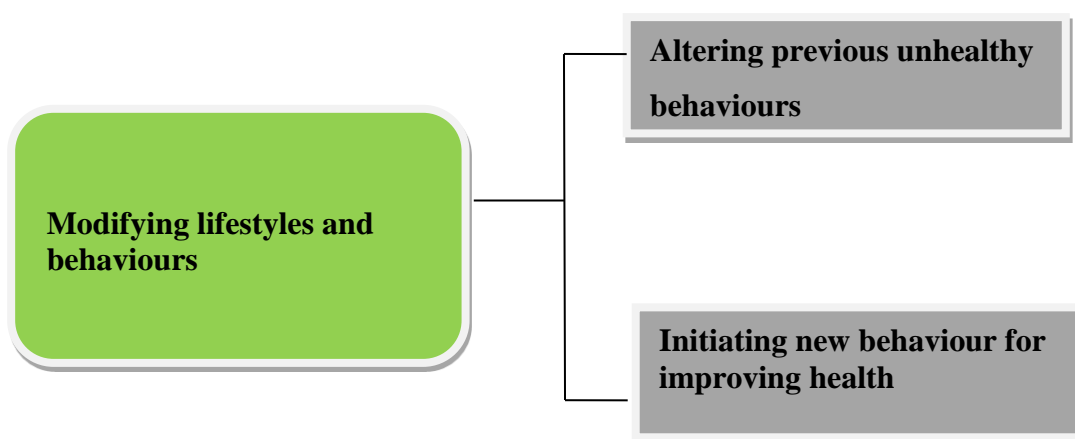
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<sup>7</sup> Zikir is denoted as remembrance of God; phrases or prayers that are repeatedly recited silently either within the mind or aloud. A person who is immersed in Zikir is able to find peace and tranquillity in their hearts and a release from the stresses and strains of day-to-day life.

that is beyond a participant's control becomes smaller in magnitude, it is supported by a different component to restore the balance.

### 5.2.4 Modifying lifestyles and behaviours

This fourth core category was about changing lifestyle and behaviours as the influential factors for improving well-being, especially in relation to maintaining or enhancing a deteriorating body. The following sections present its two sub-categories (see Figure 5-6).



**Figure 5-6: Modifying lifestyles and behaviours**

While the healthy participants realised the need to be healthy, they reported having to modify their behaviours to secure their health status. These experiences of coping and adjustments were prominent among those participants who were suffering from a terminal or chronic illness.

#### 5.2.4.1 Altering previous unhealthy behaviours

The majority of the participants mentioned that they wished to modify their behaviour to become healthier in the short-term (see Section 5.4.1). Half of the participants stated they had altered their previous lifestyle, particularly switching from being a smoker to a non-smoker, reducing their intake of foods that were high in saturated fat and sugar and doing regular exercise. At the same time, many of the participants recalled that their intentions to practise healthy behaviour had not been carried out in the past until they had come to realise its importance, notably after facing an illness or noticing their 'changing self' because of a sudden health issue.

*'She is married and childless. She has been suffering from an acute inferior STEMI with right ventricular involvement since 2012. Until 2016, her medical record showed that she had been admitted once to hospital, in December 2012. She has since stopped smoking and reported as engaging in a simple exercise routine at home. She seemed to be a joyful and self-motivated person throughout the two interview sessions. She had worked as a part-time model and also as a clerk in the past; she is currently unemployed. Both of her parents died of cancer, and her brother passed away in a road accident. These tragedies have changed her view about life and that life is short, and she wanted to do her best with the time that God has given her. Her health constraint has pulled her out from her normal self, restricted her mobility and she had to change her standard practice; she loved fried chicken and fast food. She has now stopped eating these types of food that are high in saturated fat, and she has also quit smoking.'* –Memo of Shiela

Moreover, a deteriorating health status was perceived as a positive stimulus for lifestyle modifications such as stopping smoking, eating healthy food and keeping stress levels low.

*"I could see the difference after falling sick. I think that I now I am aware. My diet needed to be healthier."* – Firdaus

*"Before falling sick, I did not think about health seriously. It never came to my mind that one day I might suffer from a terminal illness. But, it happened!"* – Yusof

Awareness attained from surrounding people was mentioned as influencing some of the participants to be alert with regard to their health status and to engage in prevention activities. For example, Participant Khadtijah, whose husband was on dialysis, spent most of her time with him at hospital. She felt that coming into contact with sick people at the hospital had led to her taking greater care with her own lifestyle. Participant Noor Anis also mentioned this as an influence after seeing the 'condition of other people', as stated below:

*"I see other people's problem, such as having a foot amputated because of their lack of concerns for their health, which makes me feel scared. I try to control my diet to prevent it from happening to me... I drink tea and coffee without sugar. I don't want my foot to be*

*amputated. Because I've seen other people who have been through this.” – Noor Anis*

Some habits such as drinking alcohol and smoking were related to the participants' present deteriorating health status.

*“I've stopped smoking and hoping to cut down on alcohol too... I think I can manage my health issue, and I have to. My brother was 35 years old when he died of kidney failure. He had uncontrolled diabetes and was on dialysis for three years. Unfortunately, he wasn't so serious about his health condition until it got worse. After looking at him, I told myself that I wouldn't lose the fight against my health problem.” – Maniam*

On the other hand, the healthy participants also commented that they wished to improve their health and lifestyle in the short-term since they felt they had already stepped into old age. They viewed improving their health as a way of preventing the disability and chronic disease associated with later life.

*“...other people have made me realise that it is time to change. I have now become more aware of how important it is to have a healthy lifestyle.” – Khadtijah*

The participants with a terminal or chronic illness mentioned following the instructions of healthcare professionals regarding actions to minimise factors that might be contraindicated for their treatment and trigger a negative outcome to their health.

*“I didn't change much about my diet; I only avoided things that I could not eat. For example, 'cempedak' (a type of fruit) 'durian' (a type of fruit), anchovies and so on because they could contaminate my blood.” – Noor Anis*

In contrast, some of the participants believed that 'changing to a healthy lifestyle' was meaningless since they thought that no action could be taken to enhance their health status.

*“For me, my health condition does not matter anymore. I feel like there is nothing I can do about my illness. Back in my younger days, I did not care much when I got sick because my parents were always in good health. Now I eat everything, including food that I should avoid.” – Mei Ling*

Mei Ling, for example, mentioned that she took minimal charge of her health and only paid attention to the necessary instructions from the healthcare professionals who provided them. She stated that she had been on dialysis for many years and that she should have started lifestyle modifications prior to falling ill.

#### **5.2.4.2 Initiating new behaviour for improving health**

Those participants with chronic health conditions felt the pressure of time to engage in activities that were expected of them to improve their health status. These activities were intended to comply with medical regimens and advice from clinic appointments and to help the participants avoid behaviours that were harmful to their health. This was because certain symptoms of disease had already begun to affect their lives and threatened enjoyment under the prerogative of a healthy body. Therefore, the pressure was high among the unhealthy participants to make changes in a short-time.

*“I need rapid changes because I have a time-bomb in my body; I have three clogged arteries that could burst at any time. So, I will live a short time. I need to make changes in myself in the short time that I have. But the worry is still there.” – Firdaus*

However, the unhealthy participants reckoned that engaging in behaviour changes would help them to remain mobile without needing assistance, with less incidence of hospitalisation or at least no worsening of their condition in the future.

*“I know I have to take the medication at the prescribed time and watch my diet now. I should know the changes that happen in my body, how much I should eat. What can be eaten and what not to prevent recurrent health issue.” – Ayu*

Therefore, the time factor also influenced the initiation of behaviours among the participants with health issues, and this will be discussed in the next section.

### **5.3 Conceptual Model: Uncertainty and SA**

This section presents a summary of the conceptual model as in Figure 5-7 which was developed through the findings of this research as examined in Chapters 4 and 5.

The findings of the present study point to how the research participants interpreted SA as having the ability to cope with adversity. Some of the major disruptive events that occurred during midlife were anticipated to create uncertainty in later life, wherein such events generated a vague expectation of the outcome of their current condition and impacted on their focus for ageing successfully. The uncertainty that the participants anticipated about the future therefore led to feelings of anxiety and confusion with regards to the informed actions that were needed to minimise the intensity of the ambiguity sensed. Disruption, therefore, is a primary source that may lead individuals to deviate from their usual selves and interrupt their existing plans or the further pursuit of their goals to age successfully. Therefore, uncertainty has interrupted the process of SA. In this current study, 'managing uncertainty' has emerged as a salient and predominant theme for determining SA.

These disruptive events that the participants reported included incidents that they had encountered directly (primary awareness), while others were experienced through their awareness of observing others around them (secondary awareness) (see Chapter 4, Section 4.3.1). Mostly, the participants in the current study, rated the level of uncertainty based on a subjective measure tailored to their justification and intuition about the consequences of current adversity for their well-being in later life.

The source of disruption primarily reported were around biomedical, personal factors and socio-cultural expectations (see Chapter 4, Section 4.4). For example, the sense of uncertainty was found to be exacerbated whenever there was any disruption to the participants' health and family relationships. In particular, those participants who were terminally ill, felt that the natural decline they experienced as a result of ageing combined with their additional health problems, had exacerbated the pressure they felt over fighting with time and achieving SA. On the other hand, issues such as their children's failures, family issues, declining mobility and a fear of becoming immobile led some participants to anticipate them becoming increasingly dependent in their later

life. The potential for a lack of support from their family members led to some of the participants to experiencing disruption.

The intention to age successfully was viewed primarily by the research participants as being influenced by the level of uncertainty and the behaviours constructed to manage or minimise the perceived uncertainty perceived in the future. If the level of uncertainty becomes complex, the intention to age successfully is perceived to be low by the participants. The level of uncertainty is greatly influenced by the severity of disruptive events, the knowledge and resources that the individuals have obtained, an assessment by the individuals themselves of the risk expected to derive from the uncertainty by individuals themselves and the input of time – these factors may thus increase or decrease the anticipation of uncertainty (see Section 5.1.4).

The findings from this research highlight that the participants develop a series of coping strategies when faced with adversity. The coping mechanisms they developed were aimed at minimising the intensity of the uncertainty that they anticipated regarding the future resulting from the occurrence of disruptive events in the present.

Most of the coping strategies adopted by the participants arose from the collective efforts of the family members gathered together, in addition to those deriving from the social perspectives and those that were based upon spiritual understanding. The findings show that the participants construct selves in their middle age to face uncertainty by ‘being resilient’, ‘building interdependence’, ‘creating a balance’ between elements of successful ageing and by ‘modifying lifestyle and behaviours’ (see Section 5.2). Through these coping mechanisms, the magnitude of uncertainty was being reduced to move forward towards SA.

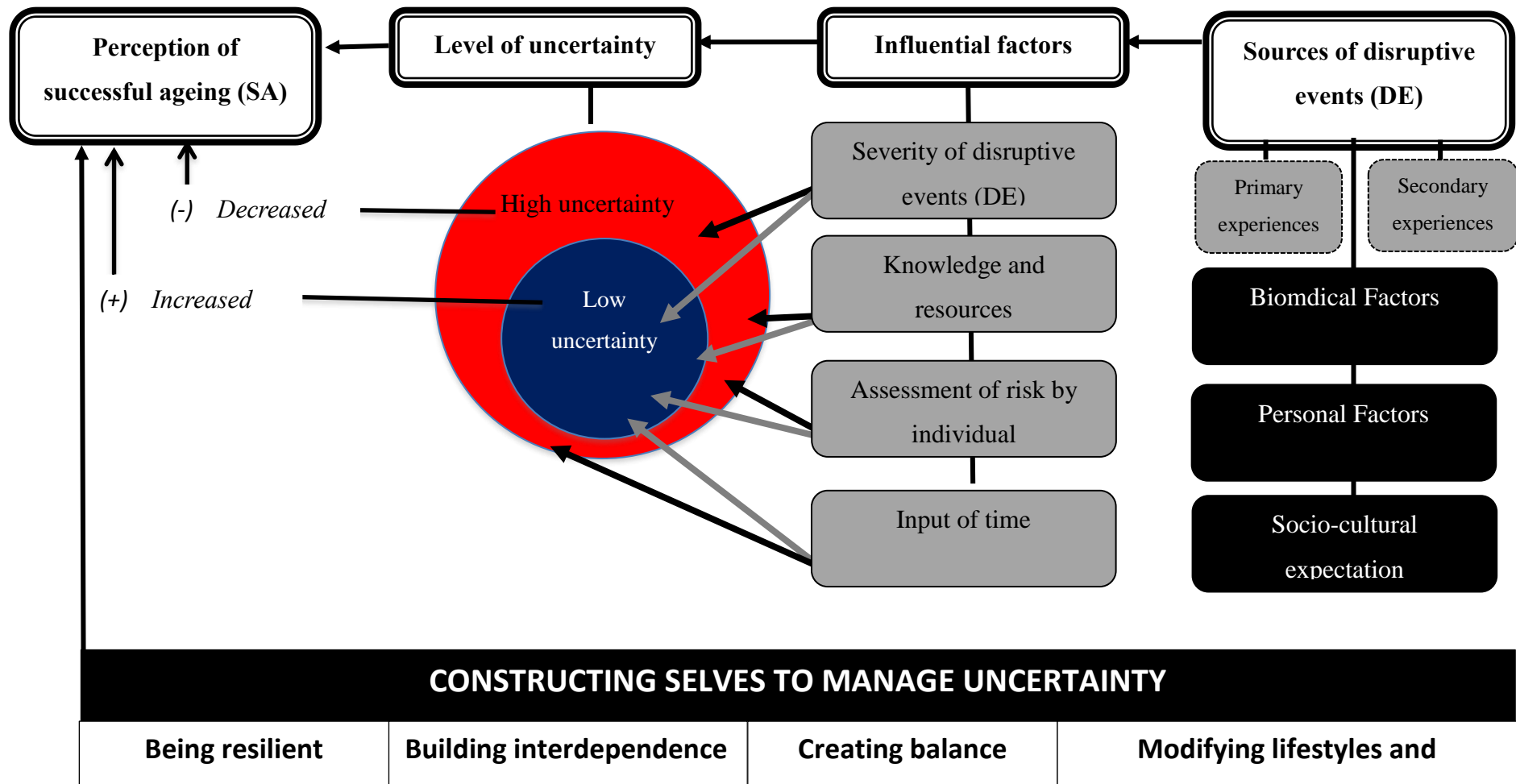


Figure 5-7: Conceptual Model: Successful Ageing and Uncertainty

## **5.4 Priority of actions for managing uncertainty over time**

The participants shared their views about the actions that influence uncertainty across the short, medium and long terms that would fit in according to their priorities (see Chapter 3, Section 3.4.2 and Appendix 22). In this session from phase 2 data collection, the participants were required to categorise the perceived factors of ‘managing uncertainty’ against timescales. They were asked to place cards into one or more category of timescales or in between two or more timescales and then discuss these at the end of activity. Through this activity, the participants discussed the aspects that were most important to them in terms of creating certainty in the present day that they were focusing on in life, in addition to the issues that they considered retaining in later life.

These findings present more data that assist in understanding the priority given to the coping behaviour mentioned in Section 5.2.

### **5.4.1 Short-term importance**

Aspects that increased the participants’ self-control, built support and improved influential factors were given attention in the short-term timescale. These included: ‘Being resilient’ (8 out of 12 participants), ‘initiating behaviour for improving illness’ (7 out of 12 participants), ‘modifying lifestyle’ (8 out of 12 participants), ‘obtaining financial security/power’ (6 out of 12 participants), ‘sustaining independence’ (5 out of 12 participants), ‘accepting adverse condition’ (4 out of 12 participants) and ‘holding good relationships with significant others’ (6 out of 12 participants) (see Figure 5-7). Although these aspects were prioritised in the present, they were also aimed at over the long term as being in the best interests of the participants. Other participants (4 out of 12 participants) also wished to focus on spiritual activities in the short-term.

For those participants with a chronic illness, financial strength was a top priority for the short-term. However, for some of the participants with secure finances, they did not mention financial strength as an issue for the short-term. This was because they had financial support from their children and their assets (e.g. Houses, health insurance).

*“It’s also money matters. It is not related to the money in our savings. For example, in my case, my children are supporting me now. So, I don’t need to think about money or be afraid of having a shortage of money to spend in the future.” – Ayu*

*“The children are our resources. The children give us money, and if it is not them, who else will give us money?” – Karim*

The participants overall highlighted all of the components of coping behaviours were important for the short-term. Community work was not considered important to pay attention at the present time. Spirituality, which was the profound component mentioned as a coping mechanism, was suggested as being significant across all timescales for most of the participants (see Section, 5.4.4)

### **5.4.2 Medium-term importance**

The participants talked about the actions that they took over the medium-term timescale, defined as between five and ten years from now. For example, they responded to generational concerns, such as voluntary work in the community or activities that would benefit the younger generation. Some of the participants from this study suggested that they might develop this activity in their later years. However, 4 out of 12 participants said they had no interest in participating in community work, as it was unsuitable for them or due to their poor state of health.

*“Community activities can be carried out if we are fit. If we are not, how can we get involved in community activities?” – Noor Anis*

*“Involvement in community activity is best when we are healthy, but unlikely if we are unhealthy and when our mobility is limited. Everything will work if we are healthy.” – Karim*

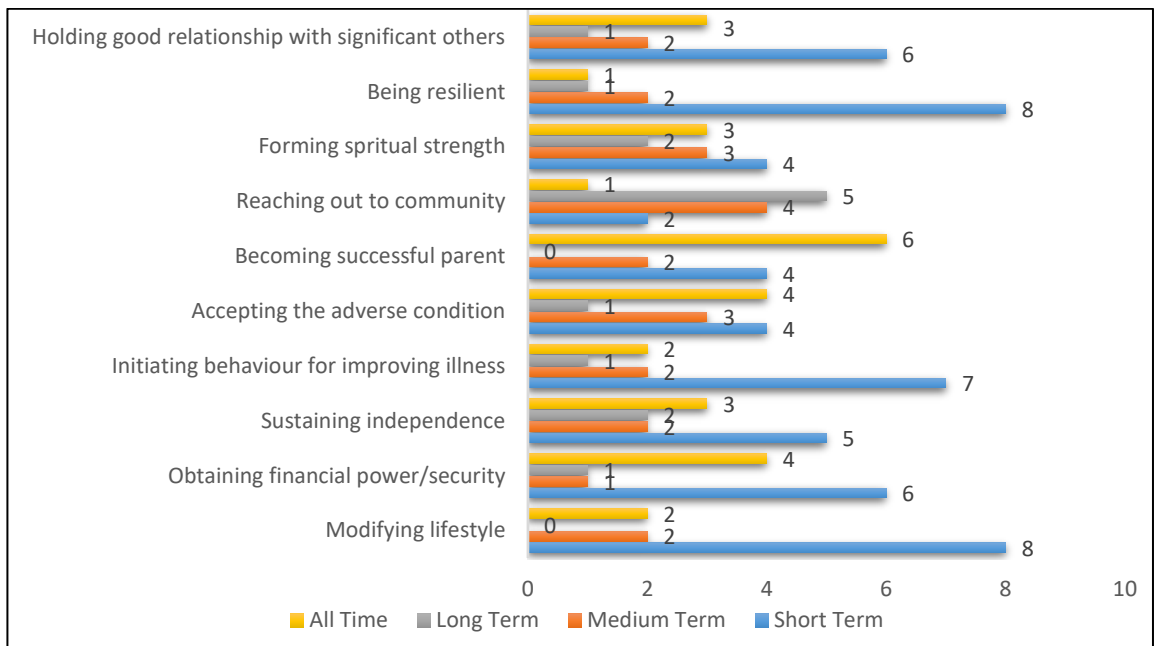
However, 2 out of 12 participants felt that they might engage in volunteering work in the future.

### **5.4.3 Long-term importance**

The participants did not categorise a particular action of ‘managing’ for long-term attention since most of the efforts were regarded as being crucial to the present. This suggests that the participants felt they had limited time and that their priority preference was to give immediate attention as a way of creating certainty in later life.

#### **5.4.4 All-time importance**

In the current study, the participants gave high importance to ‘being successful parents’ as this was seen as providing meaningfulness in later life. It was mentioned as a universal expectation and something that was continuous throughout life. Other actions that had significant percentages for continuous efforts were ‘obtaining financial power’ (4 out of 12 participants), ‘accepting the condition’ (4 out of 12 participants), ‘engaging in spiritual activity’ (3 out of 12 participants) and ‘holding good relationships with significant others’ (3 out of 12 participants) and sustaining independence (3 out of 12 participants).



**Figure 5-8 : The association between actions towards ‘managing uncertainty’ in numbers across the timeline of consciousness.**

## 5.5 Key message

The analysis demonstrates the dimensions of uncertainty surrounding the magnitude of the risk anticipated, knowledge, time and the person. This sense of ambiguity became dominant when its consequences were severe, the individual lacked information and support and due to their personal judgement of the problem and/or the novelty of the problem. Therefore, the dimension of uncertainty acknowledged by each individual varies for similar disruptive issues, such as having no caregiver, health or financial predicaments, etc. Uncertainty, therefore, can act as an important hindrance to future well-being, and the participants demonstrated various ways of both managing it and learning to live with it.

These initial data prompted and helped build further data collection on how the participants face uncertainty through constructing their selves in line with coping strategies by increasing their ability, resilience, external support and also adapting their behaviour to reduce the impact of the disruptive events in the future. The duration of such disruptive events and knowledge about the issues and risk expected to be generated by them also underpinned the effective management of uncertainty. This further data collection also revealed that the participants in this study looked for strategies to balance their predicaments with the other components of well-being, which was a unique pattern noticed from the data. Especially, spiritual understanding plays an important role in balancing uncertainty with well-being through the development of an accepting attitude based on a belief in faith, karma and al-qadar. This second data collection also highlighted that not all activities aimed at reducing uncertainty are taken into consideration for short-term actions, with the severity of the event and the impact of the disruptive issues on future life influencing the priority accorded to the actions taken.

In the following chapter, I will discuss, compare and contrast the findings of this study with those from other relevant research.

## **Chapter 6 : Discussion**

This chapter discusses the significant findings that have been presented in Chapters 4 and 5 of this thesis. It firstly discusses the predominant components identified in the conceptual model of successful ageing (SA) and uncertainty developed from the current study's findings, focusing on the ways in which some of the elements may differ from the context proposed in the predominant models of SA that were discussed in the literature review. Next, the chapter describes how the research participants developed their coping strategies in the face of uncertainty due to adverse events, which is not widely discussed in the context of SA. Finally, the chapter moves on to discuss the factors that contributed to the development of 'selves' in the conceptual model, which were identified in the analysis of this study with application of elements of TPB, comparing and contrasting these with the sense of growth that was highlighted in the existing literature.

The sections of this chapter delineate the following:

1. The dimension of conceptual model in term of identification of uncertainty and its impact on ageing;
2. The specific predictors of SA as highlighted in the conceptual model developed from the findings in Chapters 4 and 5, along with analysis from the perspective of other studies and scholars;
3. The coping strategies developed by the participants to address uncertainty and its context from works of literature, and;
4. The development of 'selves' in the conceptual model influenced by the Theory of Planned Behaviour (TPB) and discussion from existing relevant theories from the literature.

### **6.1 Dimension of conceptual model: SA and uncertainty**

To summarise the present study's finding, uncertainty leads to the development of a series of coping strategies aimed at addressing disruptive events a – defining features

of SA (see Chapter 5, Section 5.3). In this section, the identification of uncertainty by participants, the disruptive events as the source of uncertainty, and the coping mechanisms developed to face with uncertainty and age successfully will be argued against the breadth of literature reviews.

### **6.1.1 Identification of uncertainty**

The uncertainties felt by the participants are due to an unavailability of information (e.g. How they will live due to terminal illness, who will act as their carer), the unknown complex consequences of disruptive events (e.g. When they will need to use a wheelchair in the future, their children's success, future financial strain) and ambiguity surrounding their wellness in the afterlife (e.g. Would their children pray for their soul, have they equipped themselves spiritually). However, some of the predicted probability of risk was based on the experiences of others and not those of the participants themselves; for instance, the consequences of their diseases or the risk of not having a carer in the future were predicted to a certain level based on what they saw occurring in the lives of others (see Chapter 4, Section 4.3).

Uncertainty in this current study is emphasised on many different levels owing to the force of disruptive events. The study's participants face an uncertain future due to current disruptive events and risk that is predicted for their later life. The terms "disruptive events" and adversity" are defined as negative life circumstances, which link to "adjustments to difficulties" (Luthar & Cicchetti, 2000, p. 858). These negative life events or circumstances "include modest to major disruptions to daily life" (Davis, Luecken, & Lemery-Chalfant, 2009, p. 1638) and are caused by the risk, hardship and suffering associated with difficulty, misfortune or trauma (Jackson, Firtko, & Edenborough, 2007). In the face of a disruptive event, the research participants seemed to be greatly interrupted from sustaining their lives or performing as they had done in the past. Thus, disruptive events would generate significant obstruction to the continuity of 'self' into later life as it had been intended prior to the participants facing the adversity. In essence, uncertainty serves to render the making of a decision concerning the future a complicated matter.

Empirical information from their own experience combined with information gained from other people's disruptive events served to provide substantial clues with regard to uncertainty in later life for the current research participants. Therefore, the participants' approach to uncertainty with their own justification and intuition related to both actual and imaginary risks. Zinn (2016) also found that people do not follow a standard format but instead use their logic, which works well under particular circumstances. These include situations in which either knowledge or time is limited and complexity is overwhelming (Todd & Gigerenzer, 2001), at which point people will tend to complement or substitute rationality with experiential knowledge (e.g. Trust, intuition, hope) (Baillergeau & Duyvendak, 2016; Borkman, 1976; Popay & Williams, 1996) In everyday life, these strategies are necessary and regarded as a rationale for an individual to manage risk and uncertainty (Zinn, 2016).

The current research participants perceived uncertain circumstances from both personal and collective sources. The personal source was mainly based on health issues and the expectation of self-identity in later life, such as becoming a successful parent, independent, self-contented and a person who is respected by family members and society. The participants viewed attachment issues with their grown-up children, the relationship between parents, and child conflicts or failure as major factors contributing to an uncertain relationship in later life. Nevertheless, these self-identity structures were also benchmarked through societal norms and practices that were derived from collective actions (see Chapter 4, Section 4.4 and Chapter 6, Section 6.2). A vague future was highly anticipated in the event that these self-identity structures were interrupted and crucial adjustments were required to the participants' existing routines and plans. In most cases, the effectiveness of any alterations to their current plans was unknown to the research participants, therefore also contributing to their high level of uncertainty.

Although in this study health is not associated directly as a predominant component for ageing successfully (see Section 6.1.4), deteriorating health is a source of an uncertain future that is associated with other factors such as financial disruption, mobility issues and a distressing relationship with significant others. The childless couple in this study also pointed out that they would be vulnerable in later life to being

without support in the event of declining physical ability and illness. A few studies carried out among Chinese people have shown that both individuals who live alone and childless couples are vulnerable groups for depression related to future well-being (Chou & Chi, 2004). However, physical illnesses have become more commonly related to depressive symptoms in later life. At the same time, other non-health negative events can also explain some of the increase in depressive symptoms in later life (Fiske, Gatz, & Pedersen, 2003) (see Section 6.1.4). Illness was also highlighted as being triggered by the level of workload and family responsibilities in middle age (at 52) compared to in late middle age (at 61), which is a period of decreasing commitments (R. M. Helson et al., 2009). A number of studies amongst old people have reported that issues such as health (Ouwehand, De Ridder, & Bensing, 2007; Rubio et al., 2015), interpersonal (Moos et al., 2006) and other factors (e.g. Loneliness or feeling neglected, financial issues) (Moos et al., 2006; Rubio et al., 2015) are related to stressful events in old age.

In summary, beliefs about uncertainty are underlined as self-referent (Koerner & Dugas, 2008). In the current study, the participants made sense of uncertain circumstances through a process of self-referencing based on their personal, physical, psychological and environmental conditions and the information available to them. Firdaus, for example, was worried about his future life after his heart surgery. He indicated his uncertainty surrounding issues such as his job security, routine work and/or physical status that might all be adversely affected by a shift from being mobile to becoming disabled and dependent on his family. The condition of an uncertain future also varied according to the situation of adversity. The event of serious illness or perceived limited remaining lifespan, for example, generates a higher intensity of uncertainty with regard to an uncertain future compared to a situation that is resolvable.

### **6.1.2 ‘Disruptive events’ resulting uncertainty**

An ambiguous future is expected to impact on an individual’s ageing for several reasons. Firstly, middle age is considered to be a crucial period for generating self-identity and to be a time at which people find stability in locating their personalities. Therefore, having an imbalance in the development of their self-identity could pose a significant threat to the image that an individual envisions for their later life (see

Section 6.2). Moreover, middle age is a time when a person's growth reaches its peak and witnesses a transformation. The losses during this period are to be attached to a balance of biological shifts and cultural requirements. A study by Willis (2010) revealed that most age-related changes, such as bodily functions, begin to decline, and would occur at the same time as the complexity of cultural identity peaks in middle age. Willis further highlighted that early middle age might be the peak time for an individual to reap the rewards of cultural values and assets such as their education, career, relationships and family. In comparison with earlier or later periods in their life course, middle age is affected to a greater extent by the transition of socio-cultural factors (Willis et al., 2010).

Consistent with the above argument, the participants in this study also clearly demonstrated that they were struggling to balance their current identity with their envisioned self in the future, especially in the case of the male participants such as Kamaruzaman and Firdaus (see Chapter 4, Section 4.3). Firdaus, linked his current status of being economically deprived, jobless and having heart disease to a future identity of being worthless to his family. Participant Selvam, on the other hand, mentioned how migration to a big city challenged him to find stability between the values of rural and urban societies.

Secondly, a person's existing plans for their old age will tend to change permanently once they are faced with 'disruptive events', which led to increased anxiety and decreased subjective well-being (SWB) on the part of the current research participants. For example, Diener et al. (2006) reported that the different components of well-being can move in different directions and are affected by age, in addition to earlier levels of well-being (i.e. Set-points) being changed permanently. Similarly, a study conducted by Helson et al. (Helson et al., 2009) amongst ill women mentioned that SWB would decrease at the time of the leading health 'challenge' but then increase again for many sick women. When faced with disability and immobility problems, people would slowly begin to feel useless (Mollaoğlu, Tuncay, & Fertelli, 2010). Notably, a reduced capacity for self-care would alter the way people came to view their life satisfaction (Borg, Hallberg, & Blomqvist, 2006), potentially leading them to feel physically and psychologically discontented (Derahman, 2017b). Furthermore, in comparison to old

age, middle age by itself is hypothesised to be associated with an increase in the level of obligatory roles and activities, high levels of emotional change and anxiety (Basevitz et al., 2008; Lee et al., 2016). This emotional transition in self is supported by the Socioemotional Selectivity Theory (SST) (Carstensen, Fung, & Charles, 2003; Carstensen & Mikels, 2005), the theory of Strength and Vulnerability Integration (SAVI) (Charles, 2010) and the theory of Selection, Optimization and Compensation (SOC) by Baltes (Baltes & Lang, 1997; Baltes & Smith, 2003). Together, these three theories serve to expose emotional well-being across adulthood, and the prominent scope of their prediction highlights that emotional well-being is recovered in later life. Emotional strength increases in old age merely because of the information-processing style and problem-solving strategies acquired towards the end of life. There is believed to be a shift in motivation from information acquisition to emotional gratification and regulation in later life, something which is outlined in the SOC model (Blanchard-Fields, 2007; Scheibe & Carstensen, 2010). The SAVI model that built upon SST reveals how emotional well-being is enhanced by self-knowledge and social experiences (Charles, 2010). Baltes (1997), in his SOC model of ageing, proposed that individual emotional intelligence peaks during the transition from middle age to old age. Baltes also stated that during this period individuals become more skilled at adapting to and reconstructing and maintaining functional losses, in addition to minimising those losses (Lee et al., 2016) (see Chapter 2, 2.2.4.3).

Therefore, both emotional change with age and anxiety are predicted further in middle age in comparison to later life (Lee et al., 2016). Anxiety is defined as a short-term unpleasant feeling of tension, fear, nervousness and worry (Willis et al., 2010). Some researchers predict that the level of anxiety is lower in old age than in middle age because people in old age seem to have better emotional regulation with greater self-knowledge (P. B. Baltes & Smith, 2003), and the older people seem to have gained expertise in making social inferences (Blanchard-Fields, 2007). Consequently, middle age requires resources that are geared towards development, whereas in old age there is a greater allocation of resources to controlling losses (Willis et al., 2010). On the same note, Staudinger and Bluck (2001) suggested that in middle age, resources are allocated primarily to maintenance, regulation and recovery. Thus, middle age may be a unique developmental phase in which the allocation of resources is more distributed

or balanced, including growth, maintenance and regulation of loss. Previous longitudinal findings (Schaie, 2005) have characterised middle age as a period in middle adulthood between the times of young adulthood and before the decline experienced in old age in which developmental stability is achieved. However, middle age can also have a significant impact on an individual's well-being and sense of self-efficacy when compared to old age, owing to the level of control or mastery and the threat of loss due to health issues or adversity (Willis et al., 2010).

On the whole, the participants in the current study acknowledged a decrease in their SWB in the face of adverse life events. As a result, the disruptions they experienced in middle age may have triggered concerns over their quality of life and mental stage that had the potential to lead to anxiety disorder and depression in later life (Golden et al., 2011). Lucas (2007) highlighted that people would develop skills to cope with adversity and adapt to it afterwards. Coping with uncertainty is important at times when people are unable to predict what their future may look like or at what point they expect it to be miserable. As a result, they may not take actions during the present time that might lead to poor decisions for the protection of their future self (Lacey, Smith, & Ubel, 2006). The mechanisms used for coping with 'disruptive events' for ageing successfully are discussed in the next section.

### **6.1.3 Characteristics of the coping strategies shown by the research participants**

In relation to coping styles, individual differences influence the decision to choose appropriate coping mechanisms that lead to strategies that match each person (Koerner & Dugas, 2008; Rosen, Knäuper, & Sammut, 2007). A study by Rosen et al. (2007) suggests that individual differences may affect people's ability to choose appropriate coping mechanisms when faced with an uncertain health threat (p.427). Additionally, prior to reaching the phase of developing coping strategies, the participants in this study mentioned that they needed time to come to terms with what had happened to them or what may be the consequences of the adversity they faced. The length of time required varied according to each individual. For example, Kamaruzaman took almost three weeks to accept that he had had a heart attack. He also refused to take medication, which led to his second hospitalisation. Mei Ling, on the other hand, mentioned that

she was upset with her health condition but at the same time had to return to her business immediately, which meant she had little time to spend contemplating her misfortune. These individual differences in coping styles varied amongst the participants in line with their gender, ethnicity, family upbringing, motivation, external support and each individual's willpower. Coping strategies are resources used by people to decrease, tolerate or re-channel demands, which they must employ when they interpret events as being stressful (Lazarus, 1984). In the breadth of literature, coping skills fall into three different categories: cognitive, behavioural and emotional. Cognitive coping relates to how an individual reinterprets or modifies the meaning of the stressor, while behavioural coping identifies behaviours that focus on solving the problem. Through emotional coping, individuals employ a variety of resources that allow emotional expressions and stress management (Carver, Scheier, & Kumari Weintraub, 1989; Lazarus, 1984). Through emotional coping, an individual will make an effort to reduce the stress experienced from the result of the problem, and by being problem-focused, people use skills with a view to changing or mitigating the stressor. According to Moos et al. (2006), older people rely on cognitive avoidance to deal with health-related problems but tend to avoid facing other stressful events.

In consideration of the characteristics of coping skills, the strategies mentioned above have been classified as active and passive coping, problem – or emotion-focused strategies and engagement or disengagement (Carver et al., 1989; Lazarus, 1984). With active engagement, people attempt to become part of the problem in order to cope with it, in the sense that they become involved at the cognitive, emotional and/or behavioural level. With regard to the use of passive strategies, a number of studies have agreed that older people usually adapt to stressful events by accepting them (Birkeland & Natvig, 2009; Towsley, Beck, & Watkins, 2007). However, a study by Martin et al. (2001) found the behaviour of acceptance as a coping strategy to be a struggle among very old adults aged 85 years and above (Peter Martin et al., 2001). Hentz (2016), in a study conducted among older adults who had lost their jobs, revealed that to avoid dwelling on negative events, the respondents in the study coped adaptively by practising negative visualisation, taking a pause to express gratitude and recognising that their life could be (Peter Martin et al., 2001) in much worse shape (Hentz, 2016). Through the disengagement approach an individual will avoid thinking

about the problem or refuse to become emotionally attached to it, such as by changing their focus to different aspects as a way of managing the adversity (Rubio et al., 2015).

The participants in the current study seemed to cope with adversity through the use of both passive and active means. Some of the participants used problem-focused strategies, but many others used emotional attachment to address their adversity. Nevertheless, the participants used cognitive avoidance by trying to accept and adapt to the impacts of negative events. This can be related to some of the extracts mentioned by the participants: "*I hope things will get better*" or "*I follow the flow*". However, using passivity to address adversity became a means of coping only after the participants had attempted to actively engage in facing or overcoming their adversity. It is noted that certain aspects of older people's lives may change beyond their normal capability; as such, maintaining a positive attitude may help them to exercise a sense of control (Coleman, Ivani-Chalian, & Robinson, 1999).

Additionally, a few of the participants such as Ayu and Karim in the current study said that they needed to display a sense of control in front of their significant others during stressful events, especially to their children. The strategies linked to the adaptive activities undertaken among this current research community related to spirituality and the participants' way of viewing life (see Section 6.1.5.1). Moreover, a reduced sense of control related to lower health abilities is usually matched with higher adaptive strategies (Rochette, Tribble, Desrosiers, Bravo, & Bourget, 2006). Both the active and passive coping strategies displayed by the participants indicated the resilience developed during the process of dealing with adversity. Resilience is described as ongoing processes and forms of positive adaptation at the time of or following aversive events (Cicchetti & Cohen, 2006; Fletcher & Sarkar, 2013). The American Psychological Association defines resilience as the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress (e.g. Family and relationship problems, serious health issues or workplace and financial stressors) (American Psychological Association). In a longitudinal study, resilience was defined as a 'bounce back' from a difficult experience and the ability to progress forward with life (Greve & Staudinger, 2006; Windle, 2011). Resilience is an important factor that contributes to increasing well-being among human beings, especially among those

who have faced many difficulties and challenges during their lives (Fletcher & Sarkar, 2013).

In the current study, resilience was seen among the participants not only as ‘bouncing back’ but also as a process of learning to accept adversity as part of a test in life and to bravely live their future lives with all its consequences. Higher internal control beliefs were associated with more effective coping in middle age when dealing with health concerns and other negative events (Jopp & Schmitt, 2010). The findings from the current study are in line with those of other scholars, who demonstrated that the development of a fighting spirit occurs after an adverse event or a decline in well-being, resulting in them becoming more adaptable through their experiences and individuals even being able to return to their prior level or ‘set point’ (e.g. Objectives, planning) (Diener et al., 2006; Lucas, 2007). The actions engaged with for coping with problems vary according to individuals. There are a number of actions that people will undertake in order to cope with adversity. These include acting on a situation through ‘problem-directed action or assimilative’, ‘self-evaluation by adjustments or accommodative’ and ‘level of self-representation or immunising’ processes (Brandtstädter & Greve, 1994). For ‘problem-directed action or assimilative’, people tend to change situations or the way they live in line with their values, aspirations and goals that are associated with their normative self or identity. Meanwhile, ‘self-evaluation by adjustments’ or ‘accommodative’ focuses on an individual shifting or adjusting his/her values, aspirations and goals to fit existing situations as opposed to modifying them. This action of trying to accommodate the negative events tends to be invoked when the assimilative process is no longer feasible or is predicted to be ineffective. The level of self-representation or immunising involves the way in which individuals process information to defend themselves against risk and threats to a positive self-concept (Brandtstädter & Greve, 1994)

Overall, the findings from this current study indicate a clear advancement in coping strategies in the face of negative events, which the participants developed naturally (see Chapter 5, Section 5.2). A study by Zinn (2016) stated how strategies such as faith or trust, hunch and emotion are important elements that are combined with actions when participants are required to cope with risk and uncertainty. For many of the

participants in this study, having an expectation of old age to be accompanied by the consequences of major disruption in the present would produce obstacles for SA and lead to them developing strategies to improve their SWB. Nevertheless, individuals grow old and adjust to the process of ageing in many different ways (Havighurst, 1968; Neugarten, 1972). Some people maintain good control while others may struggle to cope with the consequences of ageing. The participants displayed their development of protective action against adversity on three different levels: 1) the personal level (e.g. Psychological), 2) the family level (e.g. Family unity, support from extended family) and 3) the society level (e.g. Support from public and private social institutions such as a religious institution, health care/policy).

Having developed the ability to cope with adversity, the participants told of having reduced losses and perceived themselves to be maximising gains, which were associated with an increase in certainty regarding the future. Some of the losses to ageing were in the following domains: physical strength, social network, financial strength and psychological well-being. The participants perceived gains or growth in their sense of maturity, wisdom and adaptability skills (e.g. Their attitude towards change and improved communication skills). This perception of loss and gain in the ageing process is related to the idea of the minimisation of losses and the maximisation of gains in the SA model proposed by Baltes and Cartensen (1996) (see Chapter 2, Section 2.2.4.3). ). However, biomedical factors are not perceived as the predominant influence for ageing successfully. The following sections discuss the absence of biomedical factors as the salient component of SA from the finding is discussed the next section.

#### **6.1.4 Absence of biomedical factors as a primary component of SA**

Absence or low occurrence of illness has been the most advocated predictor for SA (see Chapter 2, Section 2.3). However, in reflecting on the losses and gains, the participants in this study have considered illness to be a process of getting old rather than a direct loss resulting from ageing. Although the participants do not claim that SA necessarily equates to being free of illness and disability, they do indicate that making efforts to improve the impacts of illness would contribute to their well-being

in later life. These efforts can be associated with the participants' social relationships, physical activeness, emotional regulation (e.g. Resilience, sense of control) and financial burden (e.g. Reduced medical expenses).

In summary, the current findings indicate that SA among this study community cannot be based entirely on the biomedical model since the community perceive being old to be a period in which physiological limitation occurs. Therefore, the successful development of a fighting spirit to combat the physiological, social and psychological effects of ageing is related to ageing successfully. Wurm et. Al. (2008a) also suggested that it is essential to perceive ageing as an ongoing development through the adoption of a positive outlook, in addition to striving for a purpose and a meaningful life, even if such optimism is unrealistic in the event that a person is faced with a serious illness (Wurm et al., 2008a). In the following sub-sections this finding is supported by other studies.

#### **6.1.4.1 SA is coping with disease rather an absence of it**

Both the ill and healthy participants in this study emphasised how the ability to cope with the biological, psychological and social effects caused by the prognosis of a disease is the leading element of SA. To the participants in the current study, preventing their health condition from worsening, or else minimising the impacts of illness, is what is required for ageing successfully as opposed to being free of chronic illness. Hence, the findings of this study are only partially aligned with the conceptualisation of the SA model suggested by Rowe and Kahn, which was launched in the MacArthur Network on Successful Aging in 1984 (Rowe & Kahn, 1987, 1997) (see Chapter 2, Section 2.2.4.2). In their model of SA, Rowe and Kahn posited that ageing is the effect of disease, thus proposing that people who are ageing 'normally' would show age-related declines in physiological function, but that this would not necessarily apply to individuals who were ageing successfully (Pruchno et al., 2010).

Some research findings support Rowe and Kahn's model highlighting an absence of disease as the main element of SA (Berkman et al., 1993; Bowling, 2008). However, the present study findings agree with some of the predictions laid out by Neugarten (1972), in that one of the crucial factors that contributes to an individual's SA is their

personality. The determinants of personality as stated in Neugarten's research are coping style, a prior ability to adapt and expectations of life including income, health, social interaction, freedom and constraints, which influence the enormous complexity of SA. Although Rowe and Kahn expanded their initial model in 1998, with the new, advanced model sharing a number of similarities with some of the concepts from Neugarten, including social adjustment and engagement with health (Pruchno et al., 2010), Rowe and Kahn's model was highly focused on the medical components of defining SA.

#### **6.1.4.2 Ageing is associated with potential health issues**

Some observational studies provide explanations for the current study's finding that an absence or low incidence of illness and disability is less significant for ageing successfully. Firstly, as age increases, the chances of getting a disease and facing functional limitations will be higher (Butler et al., 2010) In addition, health encapsulates factors other than behaviours, such as living conditions and ageing experiences (Fogelholm et al., 2006; Jylhä, 2004). Growing old means a period with an expanding plethora of potentially debilitating consequences (e.g. Disabilities, cognitive decline and loss of social relationships) (Kusumastuti et al., 2016). Therefore, Kusumastuti (2016) claimed that individuals might not regard health as a driving force of SA. One of the best examples of this involves a participant in the current study, Salleh, who said, "*We can't prevent it (illness) as we age*".

#### **6.1.4.3 People with health issues can also age successfully**

Next, a significant number of the scholars who have studied SA argue that older adults who suffer physical, social and environmental challenges in later life also have the opportunity to age successfully (Kahana, 1996) (see Chapter 2, Section 2.3). Most of the age-related declines such as cognitive impairment which involve an element of social (e.g. Social activities), psychological (e.g. Personality, depression) and behavioural change (e.g. Consuming alcohol in moderation, abstaining from tobacco, healthy diet) and which are environment-related (e.g. Occupational attainment) are modifiable (Hughes & Ganguli, 2009). Nevertheless, every individual, including a person with impairments, should be given every possible chance of a comfortable life,

and people with a terminal illness must also find ways of ageing successfully (Butler et al., 2010). Therefore, Butler (2010) suggested that having an illness should not be seen as a barrier to ageing successfully. In another meaning, people with declining health should have a chance to optimise their efforts to improve their health condition in a way that is better aligned to SA.

#### **6.1.4.4 Older adults are perceived to adjust to the comorbidity that comes with ageing**

Although an acute or terminal health event (e.g. Cancer, a stroke or hip fracture) might change an individual's life forever due to its long-term impacts (Wurm, Tomasik, & Tesch-Römer, 2008b), when compared to younger people, older people are relatively better prepared to face certain health issues (Havighurst, 1961). According to Havighurst (1961), it is widely known that ageing is accompanied by a worsening of health. Therefore, it is perceived that health is expected to change as a person age. Wurn et al. (2008b) investigated whether a severe health event would change the subjective health of a person and whether life satisfaction would depend on age or other factors. Their study suggested that the impact of a serious health event on subjective health does indeed depend on age. Compared to younger people, the older adults showed a stronger increase in their subjective health (self-rated) following the occurrence of a serious health event. Subjective health thus has to be included in the measurement of SA. Some studies have pointed out that self-rated health is a significant predictor of mortality in older age (Mossey & Shapiro, 1982; Wurm et al., 2008b). This points not only to people with a poorer health appraisal being at higher risk of mortality, but also to those who reported good subjective health despite having poor physical health potentially reducing their risk of death (Benyamini & Idler, 1999; Idler & Benyamini, 1997). Hence, older adults are perceived to face health issues as part of the ageing process, and in the wake of health incidents, they are subconsciously prepared to accept illness and disabilities.

#### **6.1.4.5 People self-rate their health positively and subject to other conditions**

Moreover, some studies have argued that people often rate their subjective health (self-rated) higher than their objective health. Studies by Diehr et al. (2001) and Wilcox et al. (1996) highlighted how the occurrence of a serious health issue does not adversely affect the subjective health of all people; some participants maintained or even improved their subjective health despite having serious health issues. Similarly, some of the participants in the current study with a terminal illness, such as renal impairment and heart disease, suffer from physical weakening (e.g. Fatigue, nausea, muscle tenderness and lack of appetite) and are in poor health, yet they still evaluated their health as good.

Mostly, people associate their illness with other related consequences that are non-physical, such as the consequences of social and psychological well-being. Becker (1997) used the term ‘disrupted lives’ to refer to the experience of people who have suffered a stroke and for whom their health issues have contributed to different dilemmas, such as changes to their financial circumstances. It seems that the participants in this present study also associated their health with collective factors such as the quantity and quality of attention they received from their children and spouse once their health had been disrupted rather than in direct relation to the disease itself. Health issues are also highly related to the loss of an individual’s social network (Heylen, 2010). In the same context, the participants in the current study also associated decreasing health with a loss of social contacts, among family members or relatives, thereby resulting in loneliness. Therefore, a healthy family relationship positively influences health issues. Ayu, for example, mentioned how she had at times forgotten her physical pain: *“I feel exhausted after dialysis. But the joy of their (her children’s and grandchildren’s) presence overrides it.”*

Nonetheless, there was some variation in the participants’ self-rated health status. Benyamini et al. (2000) and Quin et al. (1999) outlined how psychological factors could explain why certain individuals with equivalent levels of disease have differing opinions about their subjective health. They put forward that objective health status is predictive only of physical health and not psychological well-being. With regard to the

disagreement between objective and subjective health dimensions, Perrig-Chiello et al. (2009) noted that although objective health and psychological well-being are not interrelated, it is possible that subjectively perceived health could be observed as a mediator between objective health status and mental well-being. Moreover, subjective health and life satisfaction are positively connected in the face of a serious health event (Wurm et al., 2008b). In other words, a subjective interpretation of existing health problems is directly related to psychological well-being but not to physical health concerns (Perrig-Chiello et al., 2009).

#### **6.1.4.6 Physical mobility related to living independently**

In addition to ‘absence of illness’, physical mobility is another highly researched element within the study of SA models. In the model proposed by Rowe and Kahn (1987), individuals with an absence of disability and who enjoyed active engagement were categorised as ageing successfully. The participants in this study also identified being mobile in the future as a pivotal factor in enhancing their well-being in later life. The current study participants related physical mobility to gaining independence in later life. They expressed their wish to be able to perform Activities of Daily Living (ADL) without the need for much in the way of assistance. The ADL mentioned by the participants included things such as walking, eating and taking a bath, among others. In the ageing studies literature, disability is associated with limitations in performing basic daily activities (e.g. Washing, dressing, shopping, lifting and carrying, gardening or driving) (Fuchs et al., 2013). This finding is similar to one in a study conducted among older people Singaporeans, which mentioned that older people Singaporeans expect care from their children in old age, but at the same time do not want to become a burden to their family (Feng & Straughan, 2017).

Being mobile is associated with certain aspects of well-being in later life. Physical functionality is associated with financial strength. Being at a productive age could be the reason for the research participants of this study to highly relate physical functionality with being sustained in employment. The main goal in middle age for many of the participants is to take care of the needs of their family members, which involves financial needs. The participants also associated their future image with functional continuity such as acting as the ‘lead’ of the family or as a decision-maker.

Therefore, being physically mobile was considered to be an important element that enhanced the participants' self-esteem in later life. Some of the participants even stated their preference for God to take their lives as an alternative to them being disabled and becoming dependent on others for the performance of ADL or not being helpful to the family. All of the participants in this study, both with and without functional limitations, anticipated maximising their physical independence in the future. Functional deficits such as limitations in performing ADL threatened the participants' pride in terms of them becoming dependent on family members and thus resulting in a decrease in their emotional well-being.

In some studies, being independent in old age is also associated with having financial freedom and the increased confidence to live alone. For example, Kohon (2014), in his study conducted among low-income older adults, demonstrated the complexity of the meaning of independence to the study's participants. Independence was defined by the participants in Kohon's study as being linked to choice, physical ability, living alone, having financial freedom and being able to take care of one's daily needs. Butler et al. (2010) also supported Kohon's claim that SA represents freedom from impairment and the ability to live independently. The participants in the current study discussed how the financial pressure encountered in old age might reduce their level of independence. They worried about experiencing financial shortfalls. Hence, they would need to seek medical support from family members or else be reliant upon funds from the government or through a welfare organisation. Despite the fact that financial support was seen by the participants as a responsible duty of the family members and children, being self-reliant in terms of having financial capability was also important to the participants in the present study. As such, children have become 'the future investment' who would have to take care of their elderly, which would include financial support, except for unmarried and childless participants.

### **6.1.5 Coping mechanisms developed to address adversity**

This section further discusses the central actions taken by the participants in this current study to cope with negative events in relation to ageing successfully. The important dimension of the specific predictors of coping mechanisms such as developing spiritual strength as part of 'being resilient', building interdependence and

lifestyle and behaviour modification as highlighted in the findings in Chapter 4 and 5 will be further discussed in turn. It also highlights how the participants took action on the basis of information obtained and the period of the adversity they faced. It also details how these efforts are balanced against other components of well-being, whereby as one component becomes low another component is increased in proportion (see Chapter 5, Section 5.2.3).

#### **6.1.5.1 Spiritual strength as part of 'being resilient'**

Spiritual and religious participation in adulthood seemed to be measured both objectively and subjectively by the research participants. In relation to an objective measurement, the participants talked about the imprecise number or proportion of visits to place of worships, prayers and religious activities. An emphasis on the subjective side of spiritual experiences was also mentioned as being part of the ageing process. Guiding life with spiritual understanding was seen as leading to well-being in the afterlife. Well-being in the afterlife was the ultimate objective of existence for most of the participants in the present study. They were therefore concerned about any gap in their spiritual practices from their young age up to their current days.

The main concern related to spiritual attainment seemed to be the small amount of time spent engaged in spiritual activities between the time when they were young and the present day. As such, middle age was seen as the time for closing this perceived gap that the participants had identified in their religious practices. The participants also stated that at a young age, they tended to seek temporal comforts such as working for money and enjoyment but that they forgot about the balance between worldly things and life after death. Expressions such as *"I lost sight of God in young age"*, *"when working I don't have time to go to church"* and *"I visited the mosques less at young age"* were some examples of the interview quotes that were indicative of this phenomenon. Many of the participants also stated that they now saw the importance of engaging in religious work more than when they were younger, and that they were therefore making increased effort with regard to religious practices at the present time. Additionally, the participants associated ageing with death and life after death. Being able to devote time to or participate in religious activities was seen as part of ageing successfully, especially when the participants believed that they had to prepare

themselves for an afterlife. As such, disruptive events, in particular health issues, led to increased devotion to spiritual activities among the participants, as they perceived they were fighting against a limited amount of time.

The above phenomenon is supported by psychological theories from a broad range of perspectives, such as the Socioemotional Selectivity Theory (SST) proposed by Carstensen et al. (1999), who placed a greater emphasis upon spiritual goals in later life as individuals become increasingly aware of the brevity of their remaining lifespan. Aside from this spiritual maturation, most people from an Eastern religion background see the process between middle age and old age as a spiritual advancement and as preparation for life after death. For the participants in the current study, the younger ages are seen as for spending on attending to the more materialistic aspects of life, with middle age, in contrast, viewed more as a period of preparation for well-being in the afterlife.

The findings of the current study underline the spiritual and religious participation that is associated with positive mind and resilience against adversity. Spiritual strength therefore was also widely emphasised by the research participants in coping with disruptive events in life.

#### **6.1.5.1.1 Spiritual resilience**

The current study reveals that the participants have learnt to find peace in spiritual activities. A fighting spirit adapted from spiritual understanding is one of the key components of SA that relates to coping with adversity. The practice of spirituality was often stated by the participants as one of the requirements for ageing successfully, and they also reported its use by their parents and other older adults in society as part of ageing successfully. The participants associated the act of engaging in spiritual activities with advancing age. It has been understood that spirituality is a foundation in identity development and how people are related to themselves and others. The practising of spiritual and religious activities allows individuals to feel part of a community and provides them with a sense of understanding of their place in the world, which may vary depending on time and location (Coles & Vassarotti, 2012). Furthermore, one is able to face personal tragedy or consequences with support from

the community network or through seeking to understand and find inner peace from religious beliefs (Hartman-Stein & Potkanowicz, 2003).

Most of the participants in this study turned to religion to find meaning during adverse situations. According to Koenig (2001), spirituality is described as a belief in a higher being and the quest for purpose in life. It is a path used by an individual to seek meaning in life events. Therefore, spirituality and religion are used by the older people to cope with life's challenges and to maintain their psychological well-being (Koenig, George, & Titus, 2004). Spirituality is seen as a compensation power for unanswered questions, despair and also as a way to attribute meaning to the seemingly absurd (Thoresen & Harris, 2002). For instance, Kamaruzaman demonstrated that coping with anxiety through religious activity is a powerful source of finding meaning in times of personal adversity and crisis. Adversity can also be associated with unknown benefit. Salleh, for example, reported how having a heart attack served as an incentive to stop smoking.

There is a wide breadth of both Eastern and Western literature related to how finding faith and peace concerning individual experiences, success and failure and future risks can be transformed through religion (Dalby, 2006; Pincharoen & Congdon, 2003). Eastern religions and practices strive to nurture harmonious adaptation to adversity, taking the view that every incident in life happens for a reason, which can either be known or unknown to us. A study conducted among South Asian people with Type 2 diabetes in the UK also demonstrated that individual's engage in activities that may be detrimental to their diabetes management because diabetes was viewed as a test from God and the participants believed that life is preordained and predestined and individuals have no ability to amend the future (Macaden & Clarke, 2010). According to Daoism, the ultimate law of the universe is living in harmony with nature simply by following the flow of living, ageing and dying. In other words, human beings are not supposed to go against the natural cosmic force. Daoism believers associate growing old with dying as part of a natural process (Kok & Yap, 2014). In comparison, in the Western culture living is defined as an individual's worth in terms of their active engagement in work, personal achievement and recognition, and a person is accountable for their own actions (Sanchez-Burks et al., 2003).

Therefore, accepting the impact of adverse events is a unique way of coping and is something that is encouraged in the Daoist community through spiritual understanding. Participants Yong and Shiela demonstrated the best examples of this from the current study. Both of these individuals reported that they seek to go with the flow of life and accept what has happened in the past and what may happen in future since they are meant to happen. Those adopting Buddhism as their religion or belief system (e.g. In Malaysia, it is mainly from the branch of Mahayana) are encouraged to take note of the impermanence of the world and avoid human cravings or lust and to do good (e.g. Individual's thinking and actions) (Kok & Yap, 2014). This would then result in an accumulation of good karma and the attainment of nirvana after death. Therefore, "the transiency of life and the suffering that accompanies old age, sickness and death are dialectic staples in oral and written dharma (reality, truth, morality): messages in all Buddhist traditions" (Nakasone, 2008, p. 214). Kok (2014), in her paper, highlighted how Malaysian-Chinese people experience ageing from their non-combative stance of submissiveness as a series of natural processes. As part of this, they go with the flow in accordance with their religion and the philosophy of religion.

This study's Malay participants with a Muslim religious background indicated their contentment with what life has to offer using the indigenous words "*Alhamdulillah*" or "*syukoor*". Both of these words have a religious connotation. 'Syukoor' is an Arabic word that is frequently used by Malay Muslims to show gratitude to God who provides a fortune, while *Alhamdulillah* literally means 'thank you God' or 'all praise to God' and is similar to the Hebrew 'Halelu Yah'. 'Alhamdulillah' and 'syukoor' are frequently used by Malays to indicate thankfulness and contentment with what has been given to them, regardless of what this happens to be (Dahlan, Nicol, & Maciver, 2010). The non-Muslim research participants also mentioned phrases such as "*It is normal when you get old*", "*I am blessed*" and "*what more can be expected*" (see Chapter 5, Sections 5.2.1.1). However, being content is not the same as having no desire to change or improve one's life situation; rather it aims to facilitate the highest level of appreciation with regard to what one already has in life (Carson, 1981). The findings of the current study indicate that the participants were attempting to be contented and thankful for what life had offered them while at the same time working to reduce the impact from their negative situations.

However, adaptation to adverse situations is not merely derived from spiritual perspectives. The present research participants eventually employed a series of adaptive strategies such as using social support, accepting sudden changes and developing new skills to aid them towards self-reconstruction. Moreover, successful adaptation to a serious negative event is recognised as an important element of resilience (Luthar, Cicchetti, & Becker, 2000). A further actualisation of adaptive skills in ageing successfully can be explained by the SOC model proposed by Baltes (1997) (see Chapter 2, Section 2.2.4.3). Baltes explained how losses in old age, such as physical, social, psychological and functional losses, can be alleviated through three types of adaptive behaviours: 1) making a selection from the choice of desired goals, 2) optimising the available skills or strategies to achieve the goal and 3) compensating for the desired functional outcomes in response to losses in goal-related achievement.

The participants also learned to appreciate their life by making positive comparisons with how their type of present situations were analysed and handled by other people. Participant Mei Ling, for instance, was not expected to survive with her renal failure for the past 13 years. Surprisingly, however she did, and she said that not everyone could survive this predicament. She also mentioned that looking at some people with a similar health issue, she noticed how they were still able to smile and enjoy life on their terms, which motivated her to restore her positive attitude towards life's challenges. Making a favourable comparison between oneself and others has been found to be a dimension of successful or good ageing (Tanner, 2007a). It is also an adaptive strategy that can be used to enhance the perceived quality of life (Graham Beaumont & Kenealy, 2004). As a coping strategy, the participants in the current study were also able to view their own unfortunate situations against a variety of benefits across the longer term. Noor Anis, for example, felt grateful to be alive and with her children. She considered this to be a blessing rather than a misfortune and it made her less concerned when facing the challenges of ill health. This view was also supported by the spiritual practices that were discussed in Section 6.1.4.

The participants were also able to retain a sense of 'doing well' by modifying their self-expectations. Adapting to the effects of an adverse situation was identified as a strategy to motivate them to continue fighting. A modification of expectations and a

lowering of aspirations to accommodate their changed circumstances and capability appeared to be effective for the participants when used in conjunction with the cognitive process and lower anxiety level (Tanner, 2007a). Participants Karim, Mellisa and Selvam, who had been affected by the interruption of filial piety in modern society, shifted their expectation of relying on their children to take care of them in old age to other options such as seeking help from relatives or opting for a place in a private care home. Moreover, individuals expand their horizons as a result of the positive and negative events that have taken place in their lives, along with social perspectives. Moreover, from a life course perspective, when individuals grow old they continue to develop and experience many changes personally and in their relationships, thus taking their individual history and relationship experiences along with them (T. C. Antonucci & Akiyama, 1995)

Some of the participants also believed their life now to be a consequence of their past behaviours. This belief was based on the philosophy of faith and karma through spiritual understanding. The participants associated a variety of past actions with the occurrence of their current situation, such as unhealthy behaviours; not being vigilant with regard to the important requirements of life, such as missing the opportunity to get married, and not attending to the early symptoms of any health changes, among others. Threads of continuity between the past, present and their perception of the future seemed to be a dimension of 'coping' for older people that supported a coherent sense of self (P. G. Coleman et al., 1999; Tanner, 2007a). This also included how their present actions would determine their future self. However, coping is a matter of personal will and determination. Positive evaluations of the 'inner self' are emotional and intellectual resources and a significant source of self-esteem (Baldock & Hadlow, 2002). Thus, the combination of a perception of doing well and a belief among the research participants that they were the ones responsible for creating their own situations, such as for Salleh in the current study, appeared to contribute to a positive self-evaluation about adversity (Tanner, 2007a). Similarly, according to Karim (2007), there are several ways in which people imagine the future: 'future as fate', 'future as fortune' and neither of these. By 'future as fate,' people believe that their future has been predetermined by God. On the other hand, with 'future as fortune', people trust that their present actions (e.g. Stopping smoking, exercising) have the potential to alter

their future (Adam, 2008). For others, they do not believe that life is predetermined either by God or by luck, instead feeling that there is little, if anything, that they can do to change it.

The bad situations encountered by the participants were associated either with bad fortune or a challenge by God or chosen by God to test their faith and strength. The participants perceived themselves to be lucky if they had a good family, spouse or life partner, children and good friends, in addition to being physically healthy and leading a peaceful life with minimal problems. On the other hand, negative events would come in the form of unexpected issues such as health problems, accidents or relationship issues with significant others. The participants also indicated that God predetermines the future; as such, being anxious or worrying would not be helpful in terms of their capacity to deal with negative events. Hence, the best ways to address adversity are to pray for the right thing to happen or to accept it as it is and make the best of what it turns out to be. Additionally, it was considered important to make the requisite efforts for life after death in relation to how Eastern cultures believe that death is not the end of life but rather a transition to other forms of existence (Gire, 2014). However, some research has shown that spirituality might not always be seen as relevant for building resilience as it is also dependent on factors that can influence SWB such as culture and life experiences (Ghaffar et al., 2013; Lawler-Row & Elliott, 2009). Anderson (2003) also pointed out how atheists still try to find meanings behind the cause and effect of any tragedies that befall them.

#### **6.1.5.2 Building interdependence**

The influence of family relationships and social support which were identified as the major coping mechanisms by the participants will be discussed in the following sections.

##### **6.1.5.2.1 Family connectedness during disruptive events**

In Asian countries, the family is considered to be a trustable institution that can be relied upon by family members (Ramaswami, Huang, & Dreher, 2014). It also has a function as a care institution for the older adult members in the family (Dahlan et al., 2010). In Malaysia, family members are mostly expected, as a lifelong goal, to live

together and to engage in activities of family life. A common social norm is that a man stays with his parents and take care of them, even after he is married, while a woman will stay with her family until she gets married. The focus on family in Malaysian culture includes not only immediate family members but also extended family members and relatives. The size of families in Malaysia is therefore relatively large, and it is common for all family members to live under the same roof. The participants in the current study expressed how old age is objectively measured around family enrichments (see Chapter 4, Section 4.4.1.1). The findings of the present study suggest that the participants' SWB is expected to increase by virtue of them living in a supportive family environment (e.g. Marriage, having children, etc.).

The terminally ill participants in this study in particular revealed the need for family attention during difficult times. Family attention was the main element that helped these participants to bring clarity to their situation, in particularly with regard to uncertainty surrounding health status. Some research evidence has suggested that personal experiences and social contexts, along with pathophysiology factors, can determine the development of disabilities and diseases (Deborah et al., 2007; Siebert, Mutran, & Reitzes, 1999). Kamaruzaman mentioned that he could have been miserable during the time he had health issues and a complicated relationship with his children. However, with the support of his wife, he was able to deal with his stressful situation. He stated that the *“role of a wife is important ... in my case, that was what prevented me from being ‘wild’ (behaving out of accepted norms)”*. A significant number of the married participants in the current study were concerned about the potential for issues with caregiving in the future. The main concern related to declining health was losing sight of who the caregiver would be in the future.

It is evident that support from other family members could become more important at certain life stages. Stafford et al. (2011), in their study, mentioned how their finding provided evidence in support of the hypothesis that other relationships become more salient for emotional well-being in the absence of a spouse or partner. In particular, exchanges with children and other family members are more strongly associated with depression amongst widowers in comparison to participants that have all types of relationship. Stafford and colleagues considered the possibility that physical health

conditions become more important as a predictor of depression at older ages. However, the mental effects of the negative and positive elements of a relationship may depend on the type of relationship (Stafford et al., 2011). A negative marital relationship and negative exchanges with a spouse, friends and other relatives were also independently associated with depression (Schuster, Kessler, & Aseltine, 1990).

Although research studies have shown that filial piety can serve a protective function to reduce stress (Zhan et al., 2011), it also could place a burden on adult children (Lai, 2010). A study by Danely (2010) stated that older Japanese women considered adult dependency to be a shameful concept within Japanese advanced modern society (Danely, 2010), which is similar to the Western SA model that places an emphasis on productivity (Kok & Yap, 2014). However, the older Japanese women's concept of self-reliance is still a relational concept, as they do not wish to trouble their family members, which is qualitatively different from the Western concept of 'independence' in old age (Kok & Yap, 2014). A majority of the participants in the current study also did not wish to bother their family members when it came to seeking assistance with ADL (see Chapter 5, Section 5.2.1.2). Instead, they wanted the children to take care of them in other aspects, such as with regard to financial aid and their psychological needs. For instance, Noor Anis said she had wished for God to take her life if she were to become physically disabled and a burden to her family members. On the other hand, Kok's (2014) study emphasised how there were reciprocal expectations from her study's participants to have family members and children take on the formal and informal long-term caregiving such as each family member, including the elderly, sharing the family chores (Kok & Yap, 2014).

According to some scholars, the reason for the phenomenon of the loss of the filial piety system may be related to the changing social characteristics of people in Malaysia as a result of urbanisation and modernisation of the population (Asayesh & Bahramizadeh, 2011; Mutalib et al., 2016). This is a phenomenon that is also occurring in many other Asian countries and the Asian community who have migrated to a Western country (Dong, Zhang, & Simon, 2014; Lamb, 2013; Y. M. Lee, 2007). The deconstruction of social structure comes as a result of the recent phenomena of women participating in the labour force, shrinking family sizes, changing values and the

migration of the younger generation to urban areas where there are more opportunities for work and education (Selvaratnam & Tin, 2007). As a result, the extended family structure has now been swapped for a more nuclear family structure, which is consequently affecting and distressing the role of the family as the caregiver for the older adults whose health conditions are in decline (Selvaratnam & Tin, 2007).

#### **6.1.5.2.2 Being a productive contributor in the family**

Being productive in the family offers another means of being prepared to cope with adverse events. The participants in this study considered themselves to be active contributors to their family well-being in later life. Apparently, the typical representation of the older adults in Malaysian culture revolves around lineage and familial headship (Kok & Yap, 2014). Therefore, an elder is seen as a significant person in the family (Dahlan et al., 2010). According to Kok (2014), Malaysian married women hold the value that after raising their children, they continue to contribute to the family by taking care of their grandchildren. Noor Anis and Kamaruzaman in the current study were still taking care of their grandchildren, while Kamsiah wished to spend her later life with her grandchildren. Most of the participants also sought attention from the family with the arrival of grandchildren, as stated in the study by Kooshair et al. (2014). Additionally, coping with loneliness through grandchildren is supported by Lorenz (2010)'s study. Lorenz (2010) stated that women with a disability articulated the significance of staying connected to their family and friends as a means of coping with a stressful time.

#### **6.1.5.2.3 Strengthening the family relationship through effective communication**

Since the family relationship is the dynamic source of a variety of disruptive events, a lack of effective communication skills had the effect of intensifying the adversity for Kamaruzaman, Maniam, Selvam and Firdaus. Many of the female participants such as Mei Ling and Noor Anis spoke about the maturity, they had developed in communication that helped them to remain attached to their children in comparison to the male participants in the present study. Brennan (2002) reported that men were more likely to rely on support from their immediate family, while women were more likely to utilise non-family social supports (Lee & Brennan, 2002). With regard to gender responses towards social support, there is an established notion that over a life course,

females would provide more support than males (Antonucci & Akiyama, 1987; Fiori et al., 2006; Gurung, Taylor, & Seeman, 2003; Krause & Keith, 1989; Okamoto & Tanaka, 2004). Therefore, it can be difficult for males if they have not developed competency in communicating with their children.

#### **6.1.5.2.4 The influence of social institution in shaping the ageing identity**

The social identity of a person in this studied community is created by family values. Burn et al. (2016), in examining social engagement in midlife, stated that the significant life events and changes that occurred in the transition to late life explained the context of ageing social identity. Similarly, the findings of the present study are aligned with the results of a study conducted among Malaysians by Derhaman (2017b), whereby individuals learned and were taught by their parents or older people and through experiences of sharing about the core values, cultural practices and the concept of life satisfaction obtained from the family institution. Many of the participants, especially Kamaruzaman, Yusof, Kamsiah and Sidarth, mentioned the influence of their parents' ageing styles, which they felt played a role in how they visualised their own ageing in the future.

In line with the Malaysian ageing social identity, a dominant strategy for coping with a declining body and its impacts in later life is developed through the system of filial piety. Filial piety is derived from the teaching of Eastern religions, in which family values, including a strong emphasis on respect for older adults and taking care of the elderly, are lifelong endeavours of the children (Dahlan et al., 2010). Religious practices and social norms reinforce the tradition of filial piety. The most important pillar of Islam, which is the main practice in Malaysia, is to worship God, with the second priority after God being one's parents (Derahman, 2017a). Filial piety values within Chinese socio-cultural tradition have been found to be a mechanism of protection against depression for older adults (Dong et al., 2012). This is set against a backdrop of a modernisation in family relations and decreased support from family members, which is suggestive of an incidence of depressive symptoms amongst Chinese older adults (Mjelde-Mossey, Chi, & Lou, 2006). Equally, in Hinduism the family relationship is the most vital process in human development. Hindus believe

that every individual should go through a householder stage, such as marriage, with this being regarded as one of the essential 'sanskaras' (sacrament for every Hindu). Every Hindu must also marry, have children and raise them (Sharma et al., 2013). For instance, Analya in the current study told of her stress at being single and expressed that her later life would be without support and that she had deviated from the expected norms. This phenomenon was also mentioned in a study conducted among Motobu and Okinawa communities, whereby an individual who is single in this community is anxious with regard to their lonely old age and death (Miwki, 1996).

The participants in the present study created security and protection for old age through the system of filial piety. Security in old age can more broadly refer to the expectation that one would receive every means of support – material, emotional and social – that one would envision they would need in later life (Hashimoto, 2000). From such a perspective, both children and elders can be interdependent in terms of material, emotional and physical support. Tanba's (1996) study recorded a finding similar to the present study in which people internalised ageing and associated it with life events that were influenced by significant others.

However, this obligatory practice that shapes ageing identity may place stress on both sides (Lamb, 2013). For example, Mei Ling in this present study mentioned that her whole life had been spent looking for income, raising her children and serving the family, and she did not focus on improving her illness. Firdaus, Ishak, Noor Anis, Salleh, Maniam and Kamsiah mentioned that children are obliged to take care of their parents as their wealth and earnings were spent on their children's enrichment activities. Hence, the children are the investment of the parents. Analya, on the other hand, mentioned that her family has many conventional practices and that she felt she is still obliged to and dependent on her parents. She said, *"I still sleep with my mother even now at forty years old"*.

Nevertheless, family values are changing in Malaysian society. Selvam, Yong and Karim stated that older people should learn to make an independent living as a way of eluding depression if their children ignore the traditional value of looking after their parents in their old age. As a result, Yunus et al. (2017) in their study suggest that external factors such as the lack of an adequate public care system in Malaysia for the

older people need to be addressed for encouraging an independent old age. Inadequate public care systems may serve to place the older people in a more vulnerable position, along with how they would likely have to depend on their children for support (Selvaratnam & Tin, 2007). Changes in family structure had put pressure on some of the participants. Kamsiah, for instance, experienced a degree of ambiguity after her eldest son decided to break the tradition of living together and move away from the family (see Chapter 5, Section 5.1.1). She also said the behaviour of her son had created social shame that she did not wish her colleagues and friends to know about it. This is because the children, especially the eldest sons, are deemed to be the people primarily responsible for taking care of their parents (Derahman, 2017b). It would be seen as an unfortunate situation if the children neglected their duty of taking care of their parents.

#### **6.1.5.2.5 Social engagement and well-being in old age**

Moreover, with regard to social support, Asian cultures view humans as existing interdependently of others (i.e. In social relationships, roles, norms and group solidarity) as well as considering collective behaviour to be fundamental to human development (Taylor, 2004). Hence, social support is essential for the growth of well-being in old age. Predictors of social support are interpersonal communication and interaction, love and understanding, care and concern, affection and companionship, financial assistance, and respect and acceptance (Antonucci & Akiyama, 2007). Given the characterisation of social support, it is strongly associated with life satisfaction (Abu-Bader, Rogers, & Barusch, 2003; Kafetsios & Sideridis, 2006; Kahn, 2003; Kooshair et al., 2014). The social support received from children and family members combines to make up a significant social support network (Antonucci & Akiyama, 1995). It also has a positive impact on the life satisfaction of older adults (Kooshair et al., 2014). However, excessive support could diminish the sense of life satisfaction in older people in the sense that it could diminish their autonomy and independence (Silverstein & Bengtson, 1994). In fact, older adults may take the view that increased contact with family members is a sign they are losing their independence (Fiori, Antonucci, & Cortina, 2006).

The current study, however, emphasises the importance of staying connected with family and friends rather than seeking social support from others. The participants, mostly talked about how having maturity in communication with their children and others as they age would reduce the impact of disruptive events, in particular over a family dispute. A family crisis can also directly lead to children not being devoted to taking extra care of the elderly. This type of behaviour can led to conflict at old age, as social support among older people and their children are of utmost importance since the children are among the best social support to the older parents in Malaysia (Derahman, 2017b).

In the current study, the majority of the participants did not discuss their engagement in social activities, with the exception of Karim. Karim put a lot of emphasis on social participation as a means of ageing successfully. Some of the other participants stated that they were not ready to engage or participate in activities at the society level. Their reasons for a lack of involvement in social work were poor health, having to allocate more time to mending relationships with family, a lack of time and social work being perceived as not coming at the right time. Some of the participants indicated that social activities might become of interest once they had reached a very old age. However, the participants also revealed that their social activities were mostly centred around religious practices in their neighbourhood area, and networking with non-governmental organisations, notably with bodies related to social care and religious institutions. Nevertheless, the participants noted that their lifestyles were perceived as a collective entity and that they were more of a distinctive community based on societal commitments.

However, maintaining a positive relationship with society has resulted in the increased well-being of the participants in the current study. Their social activities were centred on the neighbourhood, gatherings and celebrations with friends, colleagues and family friends. Family, friends and neighbours have been found to be the traditional sources of social activities such as rituals and ceremonies, thereby contributing to the emotional and social well-being of individuals in the present study. The participants in the current study talked of 'being an advantage to others', with illustrations including being helpful to others, serving as a good example and engaging in

community work as part of their social identity. 'Being an advantage' was not only regarded as part of their work for building their identity (Mcadams et al., 1993; Miner-Rubino et al., 2004; Neyer & Lehnart, 2007; Vandewater, Ostrove, & Stewart, 1997), but was also considered to increase their mental well-being (Gruenewald et al., 2007). With regard to social engagement, most of the studies on social activities found positive relationships between the development of ageing identity and generativity.

Although the participants in the study mentioned social activity, most of them, from both genders, with the exception of Karim, mentioned that less participation in community work due to health threats and social work was not a priority task for them at present or for the next five years. Some studies have also found generativity to be associated with older adults (Gruenewald et al., 2007; Krause, Herzog, & Baker, 1992). Similarly, some researchers identified barriers, including deteriorations in physical (e.g. Heart conditions, strokes, arthritis) and mental health, financial aspects, life experiences and attitudes restricting social engagement (Gabriel & Bowling, 2004; Tanner, 2007a). Quality of life and social participation, therefore, are seen to be highly subjective and dependent on personal and environmental factors (Fuchs et al., 2013). Selvaratnam (2007), studying the 'lifestyle of the older adults in rural and urban Malaysia', found the older people living in rural areas to actively participate in the community and to be more widely involved in the activities of political parties than those living in urban areas. Selvaratnam (2007) further reasoned this by associating it with the unfriendly environment and a high perception of fear of crime in urban areas, which would put the older people at risk of being isolated and marginalised. The current study has shown that the participants preferred to spend their time with their family members, which might be related to a lack of interest in social activities.

Nevertheless, community activity has been added as a component of SA over recent decades (Fuchs et al., 2013). Many other scholars have also supported the idea of participating in community work as a means of enhancing SWB (R. M. Helson et al., 2009; Tanner, 2007a). Other social activities such as volunteering, fun activities (e.g. Gardening, dancing, writing and politics) are also positively associated with well-being, a reduction in the risk of morbidity and mortality and increases in cognition and meaningfulness (Burn et al., 2016; Hartman-Stein & Potkanowicz, 2003). In the

current study, Karim had experienced the benefits of participating in community work and therefore embraced the idea of social activity as a crucial element of mental well-being. He stated that doing community work had helped him to improve his health problems and mental well-being, increase his life satisfaction (e.g. Increased networking, self-worth, feeling needed), occupy his time and be independent. Moreover, social networks played both a direct and an indirect role in supporting Karim's efforts to manage the difficulties he faced (see also (Gabriel & Bowling, 2004)).

Another relevant perspective related to ageing successfully is 'Activity' theory, which can be considered contradictory to 'Disengagement' theory (Pachana & Springerlink, 2017; Schroots, 1996) (see Chapter 2, Section 2.2.4.1). An underlying assumption of 'Activity' theory is that the more active an individual, the greater their life satisfaction (Atchley, 1989; Moody, 2015). These ideas have led to a focus on the physical and social obstacles encountered during ageing which impede people's social interactions (Fung, Carstensen and Lang 2001). In contrast, the 'Continuity' theory of ageing reveals that people, as they age, continue with the same roles and habits that they developed during their earlier life (Atchley, 1989; Moody, 2015) (see Chapter 2, 2.2.4.1). On the other hand, 'Disengagement' theory in ageing proposes that it is acceptable for an older individual to remain inactive in the community or neighbourhood in which they live. Both the 'Activity' and 'Disengagement' theories underline the importance of social participation and interaction as predictors of well-being. These perspectives suggest that a shrinking network as a person ages will result in reduced well-being and thus a greater risk of social loneliness. Karim, in reference to his friends highlighted this social isolation after retirement. Karim pointed out that older people are at risk of mental pressure if they lead an isolated lifestyle after retirement, such as maintaining their distance from the surrounding society and friends.

Moreover, it appears that a popular conception of ageing is that everyone wishes to 'leave their mark behind' for their children to follow as they get older. This concept can be oriented towards caring for and fostering the development of others or contributing to the larger society and culture in some way (Miner-Rubino, Settles, &

Stewart, 2009). Especially in late middle age, people began to realise that they have less in the way of time ahead of them. Consequently, they may start to think about how they have been and ask questions related to the form of their contribution in the future and whether they will be able to achieve it, in addition to facing the consequences related to ageing (Miner-Rubino et al., 2004). In the present study, the participants' contributions revolved mostly around their family's well-being, with them devoting their energy mainly to their familial relationships.

### **6.1.5.3 Lifestyle and behaviour modification**

Almost all of the participants in the current study admitted to being physically inactive due to personal, environmental and health issues. The participants revealed that they felt compelled but also motivated to change their lifestyle after learning they had health problems, in addition to expressing regret in relation to their past negative lifestyles that were characterised by smoking and excessive alcohol consumption. For example, Kamaruzaman said, *"because of smoking...I was smoking since 11 years ... ahh ... if only I knew it, I wouldn't have done it"*. Some of the participants reported that altering their lifestyles (e.g. Dietary, physical activities, not smoking) would help to create positive changes to their health condition in the future. Some of the participants, such as Analya and Kamsiah, highlighted that they had made changes to their lifestyle after seeing their friends and significant others suffer from health issues brought on by harmful lifestyles. A study by Calasanti and colleagues (2013) highlighted how, as a man grows older, he starts to 'appreciate' his health and thinks 'more seriously' about his lifestyle with increasing responsibility and rationality.

Overall, most of the participants in this study reported being more inclined to make dietary changes or to quit or cut down on their smoking and drinking, but they were not encouraged to do exercise for lifestyle modification, with the exception of Participant Maniam. Kok (2014), in a study conducted among participants from the Malaysian middle-aged population, reported that her respondents also engaged in little in the way of physical activity. She further highlighted how in Malaysia, the lack of exercise facilities or public gyms, especially in the small cities, might have an impact on people's motivation to engage in physical activity. Furthermore, Cockerham (2005) perceived that a healthy lifestyle is constituted as "a form of consumption in that the

health that is produced is used for something, such as longer life, work, or enhanced enjoyment of one's physical being" (p. 55). The participants in the current study also mentioned that they were considering adopting a positive lifestyle in the short-term to prolong their quality time or to reduce the complications they were experiencing due to declining health.

Some recent studies have suggested that SA is about adapting to healthy lifestyle change. Hartman-Stein (2003) stated that the baby boomer generation would officially enter the beginning of old age in 2011, which was the time at which individuals from this generation would start to turn 65 years of age. There has been increasing evidence that if baby boomers had adopted a healthy lifestyle at age 50, then this could impact on how they feel at age 80 (Hartman-Stein & Potkanowicz, 2003). Therefore, Hartman-Stein suggested that if this cohort had engaged in certain healthy behaviours and thought patterns in their middle years, they might experience a vital, satisfying life into their 70s and beyond. Another longitudinal study by Vaillant et al. (2001) that followed two cohorts of adolescent boys (237 college students and 332 inner-city youths) to 60 years or until their death suggested some predictors of healthy ageing. These predictors were related to not being a smoker, having an adaptive coping style, not abusing alcohol, maintaining a healthy weight, having a stable marriage, engaging in some exercise and being intelligent and educated. A number of other variables tested in Vaillant's study such as ancestral longevity, cholesterol level, stress, childhood temperament, parental characteristics and ease in social relations were not found to be significant predictors of healthy ageing (Vaillant & Mukamal, 2001).

Nevertheless, the major factor in developing a healthy lifestyle is the actualisation of "choices from options available by one's life chances" (Cockerham, Rütten, & Abel, 1997, p. 325). In this present study, Participant Shiela stated that both of her parents died of cancer and her brother died in a road accident. She now has heart disease. She said, "*regardless [of whether] active or not, you will [come] down with health issues, or die from unexpected incidents*". As such, having had to live with her real-life experience, she wanted to enjoy her life fully. She disclosed that she lives her life as she wishes: "*I go with my guts, whatever I like to eat or do whatever I like to do.*"

Although this behaviour may impact upon a person's aim to age successfully, it can contribute to the participants' living in the moment and their pursuit of happiness.

The above discussion about lifestyle modification by the participants in this study highlights the components in the TPB. The intention to change lifestyle is associated with the participants' attitude to change more generally and if they believe that change will influence them to SA in the future. Mostly, a lifestyle change will be undertaken for a reason, such as to improve a health problem. In addition, the data also show that the participants do not initiate a lifestyle change if they perceive it to be difficult due to the health issues they face or the fact that they are incapable of adapting to the change. The living style of others such as parents, and the motivation derived from significant others, also influence the intention to change (see Chapter 5, Section: 5.2.2.3).

#### **6.1.5.4 Information availability**

The maintenance of mental capacity ensures that an individual has the problem-solving skills needed to deal with and adapt to the challenges of negative life events (Willis et al., 2010). To overcome challenges in life, most people believe that experiences that are accumulated across different ages will help, and as such the older adults benefited from their rich experiences (Cosco et al., 2016). Cosco et al. (2016), in their systematic review of the operationalisation of resilience found that resilience built at earlier ages through life experience is associated with resilience in later life. People gain satisfaction from experiential knowledge (Derahman, 2017b; Gilovich, Kumar, & Jampol, 2015). Furthermore, efforts to increase knowledge about ageing, including information about the probability of occurrence or about normative and non-normative events, may have the potential to reduce intolerance of uncertainty. Intolerance of uncertainty is defined as "a cognitive bias that affects how a person perceives, interprets and responds to uncertain situations" (Dugas, Schwartz, & Francis, 2004, p. 835) and the tendency to react negatively to uncertain events (Boelen & Reijntjes, 2009, p. 471). Research has shown intolerance of uncertainty and worry to be highly related (Kristin Buhr & Dugas, 2009). Nuevo et al. (2009) suggested that better knowledge of the ageing process would lead to greater acceptance of the uncertainties associated with late-life changes.

The negative stereotype of ageing which can arise from a lack of knowledge is frequently acquired early in life and is usually very resistant to change over the course of a person's life cycle (Ory et al., 2003). Adequate knowledge of the changes associated with ageing could therefore reduce the level of uncertainty and increase a person's tolerance of those changes (Levy, 2003; Nuevo et al., 2009). A lack of information about the disruptive events experienced or risk anticipated influenced the degree of uncertainty felt by the research participants in this study (see Chapter 5, Section 5.1.2). Mancuso, Sayles and Allegrante (2010) conducted a study involving patients with asthma and found that knowledge about asthma affects one's self-efficacy. Williams and Kim (2012) mentioned that those who have higher self-efficacy belief with regard to their capacity to accomplish a specific task are better able to endure uncertainty. Moreover, Makalainen, Julkunen and Pietilä (2009) found in their study that as a patient's knowledge increases, so their self-efficacy strengthens. Factors such as a higher educational level being related to higher cognitive mastery and levels of coping skills were highlighted in some studies (Deeg & Huisman, 2010; Jopp & Schmitt, 2010), but were not addressed in the current study. Having adequate information about the consequences of adversity and choices with regard to the action available would influence positive mental well-being. Additionally, good mental health, as an integral component of SA, appears to be associated with higher resilience, good adaptive abilities and effective coping abilities.

#### **6.1.5.5 Balancing with other components**

One of the salient aspects of coping with adverse events amongst the current research participants was having balanced ageing across all aspects of life. As such, when one component of well-being was reduced, they balanced it with another constituent of well-being (see Chapter 5, Section 5.2.3). This process is also acknowledged as negotiation to changes by an individual, concerned with how older people negotiate changes to the resources available to them in ways that enable them to continue to attain meaningful goals (Steverink, Lindenberg, & Ormel, 1998). When the resources available to older people diminish, they strive to minimise these losses via the processes of substitution and compensation (Tanner, 2007a). The method of ageing can be characterised as a shifting balance between gains and losses (in resources), in

which the losses increasingly outweigh the gains. “With regard to delaying and mitigating this changing balance, the substitution or compensation of resources and instrumental goals is considered to be the central mechanism of successful adaptive behaviour in ageing individuals” (Steverink et al., 1998, p. 455).

## **6.2 The development of ‘selves’ in the conceptual model influenced by the Theory of Planned Behaviour (TBP)**

This present study is anchored in the Theory of Planned Behaviour (TBP) by Icek Ajzen (see Chapter 3, Section 3.2.5.2). According to TBP, individuals’ behaviour is established by their intention to perform a certain behaviour through deliberation that moderates the relationship between norms and intentions (Fishbein, 1975). Deliberating the consequences of a certain behaviour produces positive or negative outcomes such as having intolerance or tolerance to uncertainty and worry (De Guzman et al., 2014). Belief in the consequences of adversity was established by the current participants with actual experiences and also through information gathered from incidents experienced by other people. The attitude towards behaviour of SA is shown in the present study through the beliefs of the participants concerning the series of coping strategies developed against uncertainty to increase well-being in the future. The people in this study perform ‘collective actions’ that have been identified by family members, friends and in wider society as the ‘natural’ and common way to address adversity. The participants perceived behavioural control as employed through constructing the ‘self’ through possessing some measure(s) of internal control (i.e. Through spiritual understanding, financial power and their ability to live independently), building external support through family and social relationships and by lowering the risk of impairment and achieving a balance between the different elements of well-being (see Chapter 5, Section 5.2.3).

The findings of the present study have highlighted how the participants struggle to sustain their self-identity in the midst of challenging ‘disruptive events’. The image of the future self is an advancement of one’s current being. There is extensive evidence that individuals shape their personalities and self-identity in middle age due to various contributing factors that occur during this period. As a result, middle age is related to

a crucial period of preparing for the development of ageing. The sense of 'self' can help the individual to understand and evaluate themselves and clarify what is important to them, thereby allowing them "to set and achieve goals towards living a meaningful life" (Mchugh, 2015, p. 6). Three primary factors were highly associated with the development of 'self' into old age amongst the research participant in the current study. These factors are subjective norms, behaviour intention through experiences and environmental factors. These three factors that influence 'self-construction' amongst the research participants will be discussed in the following sub-sections.

### **6.2.1 Subjective norms**

Cultural perspective is a significant factor that influences personality development in middle age. Society has a major influence on the creation of attitudes to ageing. It is difficult to distinguish cultural norms from ageing development because family members, communities and cultural practices play a large part in shaping individuals' ageing experiences (Sokolovsky, 2009). Cultural knowledge becomes an active belief system for analysing and interpreting day-to-day life experiences (Geertz, 1993). Moreover, individuals are known to construct daily life stories from social, cultural, economic and environmental factors to sustain their sense of 'self' (Tanner, 2007a, 2007b). Scheidt (2017), in his biographical paper, also mentioned the role played by societal enforcement in self-development. He pointed out how social labelling might be adopted as "self-relevant by older adults who adjust self-views to the normative expectations, which could conform to a lifestyle guided by lowered and negative expectations for performance" (Scheidt, 2017, p. 112). Moreover, cultural practice is perceived to reach its peak in midlife (Willis et al., 2010). The findings of this study also reveal the participants' sense of their self as being shaped by the collective perception from their significant others and communities rather than being dominated by personal concepts or values. Overall, the participants highlighted that their self-development takes place through their daily experiences, interpretation and remaining self-referent to their socio-cultural context.

Consequently, the process of ageing constitutes a set of accepted criteria for attributing social expectations. As a result, people will act according to the norms that define specific patterns of behaviour that are acceptable or unacceptable as they age (Manor,

2017) In the current study population, many of the participants were proud of their children's achievements. Most of the participants' happiness was essentially linked to the activities of their children and grandchildren. This is because, among the studied community, a person's image in old age is reflected through the image of their children. For example, Maniam and Kamaruzaman mentioned that their 'future self' is the image of their children. Overall, the achievements of their children contributed greatly to the happiness of the old-aged parents in this community. Kok (2014), in her study with a population from the same cultural background, found that her research participants also regarded their children's achievements as their own.

As a result, the process of ageing among the study's community constitutes certain criteria that can be attributed to local social expectations. People, therefore, as they age, will act according to specific patterns of behaviour that constitute defined norms, which are either deemed to be acceptable or unacceptable by the wider society (Manor, 2017). It is worth recalling that most of the participants in this study mentioned becoming old earlier than their biological age, thus referring to indications derived from societal norms (see Chapter 4, Section 4.2.1). Ayu, for example, said that she realised that she had become 'old' in her late 40s after becoming a grandmother led to her adopting certain behaviours associated with the older adults in this community (e.g. Increased engagement in spiritual activities, change in diet, choosing a submissive style in communication with younger individuals). Most of the other participants, similarly to Ayu, defined their identity in line with norms underlined by the society in which they lived, thus providing another layer to their sense of self. In Ayu's situation, the social 'tag' and identification created a layer of perception about her ageing 'self' and her actions towards ageing development. The way we perceive ourselves, and the critical changes that have occurred in the course of our life, as well as how others judge and categorise us, could influence the development of our identity (Nikander, 2009; Scheidt, 2017; Settersten & Mayer, 1997). Nevertheless, ageing experiences vary between different societies. Unlike the participants in this current study, other studies conducted among middle-aged Western people have mentioned how their respondents felt younger than their chronological age (Nikander, 2009; Westerhof, Whitbourne, & Freeman, 2012).

People therefore synthesise their experiences in everyday life to create an overall ageing identity, and this becomes endorsed as 'rightful' by the society. Therefore, if there was further feedback from others that was similar to that of a person who was thinking about ageing, this would have a significant influence on how he/she felt about his/her sense of ageing. This is because the expectation and appraisal of other people will support and reaffirm an individual's role identity and their imagined view of 'self'. According to Vincent (2007), it is a person's own internalised role identities that will encourage his or her behaviours. It is also because "human cultures do not only classify individuals and groups by 'age' but also develop normative expectations" about how a person should react to a certain age (p. 943). On the other hand, 'role identity' theory suggests that increased reliance on family members would threaten older adults' self-perceptions of being competent and may strengthen their role identities as needy dependents (Kohon & Carder, 2014). This phenomenon could be seen in contrast to the current research participants, since most of the participants viewed their self as being dependent upon their family members for their physical, psychological and financial well-being rather as an active contributor as they reach old age.

### **6.2.2 Behaviour intention**

Another aspect influencing the development of 'self' amongst the current research participants seemed to be their collection of past experiences. Clarke et. Al. (2018) highlighted how an individual's perception of adversity (i.e. Risk) and definition of outcome (e.g. Resilience) is based upon the impact of their past and future orientation. According to the author, by recognising the temporal accounting of older people a clear understanding will be obtained about the way an individual embraces self-reliance through developing coping strategies in the face of adversity (Clarke et al., 2018). It is evident in many studies that people tend to integrate the narrative of risky events into their personal life story (Moyle et al., 2010). For example, in responding to chronic illness individuals test the meanings attached to their "altered situation" against that which is actually happening in everyday situations (Bury, 1991, p. 454). Stereotype Embodiment Theory (SET) by Levy (2009; 2012), on the other hand, relates ageing to development over time and highlights that learning from childhood to adulthood is expected to contribute to the perception of old age. Levy's theory (2009) has four components: 1) "age stereotypes are learned early in life and retained

across a person's lifecourse"; 2) these "stereotypes are formed and operate at both the conscious (manifest) and unconscious (latent) levels"; 3) "age stereotypes can be self-relevant"; for example, when an individual subjectively recognises the onset of old age; and 4) these "stereotypes develop to increase the likelihood of exerting an influence on a person's perception of old age along with adaptation of the psychological, physiological and behavioural pathways" to ageing (p. 334). Older people relate to their ageing through stereotypical influences including, "physical and mental abilities, balance, recovery time, self-care, will to live and longevity" (Marshall, 2015, p. 519).

Similarly, the participants in this current study pointed out how they develop an image of their future selves by referring to the image of their parents or of other older individuals. Hence, the participants imagined their old age as being similar to that experienced by their parents. The participants also highlighted that the lessons they took from their parents would guide them through behavioural change. People who have had similar life events, such as the participants in the current study, tend to exhibit this type of self-referent behaviour. The data from the current study suggests that the participants are highly likely to refer to the 'stories' and 'values' of significant others concerning their perception of old age and to establish a similar measurement system for their later life.

It might be difficult for individuals to imagine how their old age might be if they have had little contact with the older people, especially in the case of younger people who always form their opinions of ageing by reflecting on what they have observed from their parents and grandparents (Phoenix & Sparkes, 2006). Nevertheless, individuals examine themselves based on others, and they contend with mixed emotions concerning the components of their identity, such as rejection and acceptance, aversion and their ability to come to terms with things or events (Manor, 2017). It seems that ageing becomes the integration of experience in which events are presented within a framework of a continuous and coherent self. Different styles of ageing derive from specific personality configurations and coping mechanisms produced against the constraints of old age, in which an identity is created by responding to life events in ways that fit individuals' personality styles (Silver, 1992).

The participants in this study also recollected past successes and failures, along with current incidents, and they tried to readdress their sense of self-transcendence from their young age to their current selves. The perceptions and experiences of one's ageing process refer to the meaning of different aspects of the ageing process as one relates to others. According to Waterhof (2012), the "ageing self is multidimensional and multidirectional" (p.52). Experiences such as changes in relationships, perceptions and the interpretations of these events impacted on the way the participants in this study relate themselves to self and identity. Selvam, for example, noticed changes in himself following the death of his wife, who was the pillar for his family unity. After her demise due to cancer, he felt that he became less close to his family members and relatives. These changes in the family relationship had challenged Selvam's image of his later life since he had expected to share a strong bond with his children and siblings in later life.

Difficult circumstances such as the death of significant others, health issues and family disputes can change the way in which participants interpret ageing experiences. A study by Katenbaum (1982) on age-related differences from a time perspective mentioned the case study of a middle-aged individual who experienced becoming old in a single moment when he/she had been diagnosed with health issues. Some of the participants in this current study, namely Firdaus, Salleh and Yusof, stated that they had experienced the realisation of becoming old in a single moment after becoming ill. On the other hand, Participant Kamsiah pointed out how the death of her best friend had caused her to worry about her old age, as she did not wish to be estranged from her family and die lonely. When her son left the family to live independently, she was worried that she might also live alone in her old age. This resulted in her resigning from her current job to take care of her grandchild as a means of bringing her son back to stay with the family in the future. Analya, on the other hand, reported that her brother's death had shaped her view of the world as a short existence. As a result, she had opted to engage more in spiritual activities. As such, life-changing experiences and the realisation of one's finitude has the power to change an individual's behaviour to establish a meaningful life.

According to the Identity Process Theory (IPT), people will tend to combine their daily life experiences with their psychological sense of self, or their personal image, and this process happens in a continuous circle (Whitbourne, 1986). According to IPT, individuals use three identity processes in negotiating new experiences associated with the ageing process throughout adulthood: 1) identity assimilation; 2) identity accommodation; and 3) identity balance (Sneed & Whitbourne, 2003).

Through ‘identity assimilation’, adults attempt to maintain a sense of self-consistency when faced with physical, cognitive and social age-related changes. Thus, through identity assimilation, adults show minimal conflicting representation of self of what has been previously established about them. In the second process of identity development, which is ‘identity accommodation’ people make changes to the self by having new experiences, which conflict with their existing self-schemas. In the third identity process people maintain a sense of self but change this when necessary (Sneed & Whitbourne, 2003; Westerhof et al., 2012). Participant Mei Ling, for example accommodated new and challenging life circumstances. She said that she had lived a hard life in the past when faced with a series of health issues when her children were little. Mei Ling related her self-identity to a lady whom she met in the hospital where she was admitted for renal failure. The lady Mei Ling met was seen smiling although she had a short life. This encounter changed Mei Ling’s sense of self and motivated her to fight against the impacts of her health problem.

Similarly, in a nationally representative German study, it was reported that the personal experience of ageing comprises three dimensions: physical decline, social loss and psychological growth (Steverink et al., 2001). However, factors such as education, social relations and health influence are said to have different dimensions. The German ageing survey mentioned above also showed that a more positive ageing experience is related to higher subjective well-being. Regardless of negative experiences, having positive perceptions of ageing predicts better functioning in later life (B. R. Levy, 2003).

### **6.2.3 Supportive environment to influence perceived behavioural control**

The other factor contributing to the development of the perspective of 'self' amongst the current research participants is environmental determinants. Participants such as Maniam, Siti and Selvam shared a similar background and highlighted the differences they expected to experience with regard to ageing if they were to stay in the village. All of these participants had moved from rural communities to the city to find high-income jobs and to provide a better education for their children. Their move from the village to a modern and busy overpopulated city had exhausted them in many ways, along with their advancing age. The differences in behavioural control mentioned by these participants mainly concerned having to deal with the dilemmas between conventional and modern values, the challenges and adjustments they faced with regard to the new environment and the stress of disconnecting from their extended family members. Having moved his life from the village to the city for a period of 20 years, Maniam mentioned that he had noticed his family values had changed.

The next section will discuss in turn the element of uncertainty and how it affects the individual experience of the ageing self, and the development of predominant coping strategies among the participants in the present study.

## **6.3 Key message**

Successful ageing (SA) is not about objective measures; instead, its evaluation is subjective and also culture-dependent. The SA seen among the present study population is characterised more by collective actions than being based solely on individual focus. The salient factor that contributes to SA among middle-aged adults is coping with the negative events that can lead to poor ageing in the future. Such disruptive events that are faced in middle age serve to interrupt the development of the ageing self and cause anxiety amongst the participants with regard to later life. The current study describes how individuals try to achieve SA in the face of adversity by minimising the level of uncertainty in later life. The participants' perspectives suggested that the central resources for ageing successfully were based on family relationships and spiritual attainment. The coping strategies developed by the participants were based on the familial and societal level as they sought help from the

people with whom they shared emotions and concerns. As such, human relationships and social support amongst the older people and their children are of utmost important since the children count among the best form of social assistance for the older parents within this community.

## Chapter 7 : Conclusion

This study seeks to expand the understanding of the key determinants of successful ageing (SA) in middle-aged adults. The study's initial findings focused attention on the risk associated with uncertainty; its further exploration was then narrowed down to interpreting how the research participants react to and cope with the adverse events they experience that affect their well-being in later life.

An improved health care system and falling birth rate have served to increase life expectancy in Malaysia. The proportion of 'young old' in Malaysia has increased steadily since the 1990s. Malaysia will have become a nation with an ageing population by the year 2020, with the phenomenon of an ageing population being a new concept for Malaysia and its people. The right support policies, public health interventions, incentives and effective care will enable people to experience better ageing. To define SA among the Malaysian community, the present study was informed by the following objectives:

1. To identify the concept of ageing according to middle-aged Malaysian adults.
2. To explore the normative beliefs, societal norms and external and internal barriers reported in achieving successful ageing.
3. To understand uncertainty, its impact and how middle-aged adults cope with it to age successfully.

The findings in Chapters 4 and 5 of this thesis discuss the objectives underlined in this study, using appropriate research questions to identify the prime factors that are associated with SA. The grounding findings of this study direct the learning of the researcher to understand how individuals cope with the adverse events in midlife that potentially affect their ageing experience. Dealing with negative events, according to the research participants, demands a balance between physical, psychological, social and spiritual aspects. This chapter further articulates the study's findings and highlights its strengths. It also discusses its limitations and provides some recommendations for future study. At the end of the chapter, the unique contributions of the study's findings to theory, policy and to education and practice are highlighted.

## **7.1 Articulation of study findings**

### **7.1.1 Research objective 1: Perspective of ageing and factors contributing to the construction of the 'ageing self'**

This study presents evidence that ageing can be viewed as a strength in terms of the experiences obtained, maturity, stability and achievements. However, at the same time, growing old also seems to pose risks, including exposure to health issues, changes in levels of physical capability, reduced emotional well-being and stress from linking present experiences to future living, amongst others. These changes in middle age were found to have an impact on the individuals' sense of the 'ageing self'. The changes experienced by the individuals during their lives as they have grown old, such as changes in health status, physical strength, cognitive maturity and spiritual attainment, made a particular contribution to the identity of ageing. For example, as the individuals aged, their perceived priority in life transformed from temporal achievement to taking steps to ensure their well-being in the afterlife.

Cultural and social beliefs make a significant contribution to an individual's experience of growing older in many ways, as found in the way in which society acknowledges them, their participation in specific activities and the support they can expect to receive from their family members and the community at large. Social constructs such as marriage, being a parent and participation in spiritual and religious activities were classed as essential aspects of acceptance in society as one ages. The participants highlighted that having a health condition served as an indication of ageing. The individuals in this study made comparisons with other individuals with chronic illnesses within their circle and used these to make inferences about getting older. The stress related issues that accelerate ageing among unhealthy individuals should be addressed effectively.

### **7.1.2 Research objective 2: the beliefs, societal norms and barriers that influence successful ageing**

The present study also aims to gain insight into the beliefs, societal norms and factors that motivate and hinder SA.

In the Theory of Planned Behaviour (TPB), attitudes are deemed to be the result of an individual's beliefs about the outcome of participating in a specific behaviour (Ajzen,

1988; Fishbein, 1975). The current research participants' opinions about ageing are constructed from both their personal experiences and by observing others as a process through which they make sense of their own ageing self. The images and behaviours of significant older members in the family, colleagues in the workplace, neighbours and friends, have each helped to build a series of perceptions about ageing amongst the present research participants.

These perceptions suggest a certain 'ageing identity' among the research participants which can also be attributed to their behaviours. The lay views about ageing are complicated and multidimensional. They relate to the contribution of family members, the achievements of individuals' children, understanding of spirituality, the recognition received from society and the ongoing sense of meaningfulness in life, all of which combine to develop a personal identity of ageing. These parameters help to determine quality of life in older age and become a yardstick for measuring the success or failure of old age. Certain situations experienced by the people around them were taken as important references by the research participants to decide upon their problems in life. The lives lived by the participants' parents, other family members and work colleagues all served as substantial references for the participants. These experiences gathered from other significant people become a salient source of information when the individuals found them to be self-relevant. Therefore, the factors that influenced and also hindered SA among the research participants were conceived from their surroundings. Attitudes are defined by an individual's belief regarding intended behaviour (Ajzen & Driver, 1991; Ajzen, 2002). Relatively, the participants believed illness to be a result of their fate and past karma, which they perceived as being beyond their control. In a study conducted on the perceptions of health among British and American elderly, it was revealed that the study respondents felt responsible for their health and viewed it as a personal accountability (Van Maanen, 2006). In the present study, however, personal health and well-being were not regarded as being the responsibility of the participants but rather were considered to relate primarily to family members, relatives, friends, neighbours and community members.

Hence, the development of interventions or public policy related to a healthy lifestyle needs to be multidimensional and also include individuals' social contacts.

Individuals' beliefs regarding health status and ageing need to be re-emphasised by health educators by pointing out that, in the process of ageing, interventions from surrounding people and the environment will be far more beneficial and effective in maintaining their well-being in later life. Culturally accepted strategies need to be addressed to increase Malaysian middle-aged people's awareness regarding their ability to manage their health issues through preventive measures. For the participants in this study, one's own health is related to the well-being of family members and significant others. Hence, health care professionals need to recognise individuals' personal beliefs and help them to define health status, to include encouraging them to personally take responsibility for their own health. Middle-aged adults may be helped to age better by exercising accountability for their own health, such as by adopting a healthy lifestyle, planning for medical care and making choices related to their own health instead of expecting their children or other family members to do it.

Social recognition is pivotal for the people in this study, but they were reluctant to participate in any community work in middle age. For most of the participants, being present for the family and making an effort to improve their well-being was more relevant. Health status typically became another barrier to them engaging in community work, with the participants tending to feel that they were not fit enough. The participants' negative beliefs with regard to ageing, combined with their poorer health, tended to develop over time. These beliefs were influenced by the multiple and external sources that people may experience unconsciously but which later become salient when individuals find them to be related to their own situations (Jarrott & Savla, 2016; Levy, 2009). Therefore, the response from the present research participants confirmed that culturally accepted interventions are required with respect to individuals who suffer from illness in order that they can still feel confident to be active in society, even with a lower health status. This measure could help to increase an individual's sense of belonging and would be relevant to improving their well-being in later life since the sense of belonging to a community is one of the components of SA, as emphasised by the research participants. According to Erikson (1950), parenting is also a prominent expression of social generativity. Therefore, engaging directly in community work should not be considered only as social generativity but rather as an action that might increase the sense of meaningfulness.

### **7.1.3 Research objective 3: Experience, priorities and support needed to cope with uncertainty**

The present study was originally designed to gain insight into the constructs of SA and its meaning and significance for the Malaysian middle-aged adult participants. In general, the research on SA has been highly concentrated on activities that might mitigate SA and has been relatively poorly aligned to the issues that would prevent individuals from participating in activities that encourage SA. The present study participants seemed to recognise those factors that would facilitate successful ageing but were concerned about certain issues that they saw as making their future state uncertain. Coping strategies to deal with the sense of ambiguity that is commonly faced in older age appeared to be the ultimate goal that the research participants strived for; with some of them highlighting how those uncertainties prevented them from planning for their well-being in old age. Uncertainty was the critical barrier with respect to preparing for later life and consequently triggered anxiety with regard to ageing. The participants perceived the sources of uncertainty to be multidimensional, and while they cited almost the same sources of uncertainties, the extent of the ambiguity they experienced varied according to the source(s) of the uncertainty.

The consequences related to health are the significant concerns of uncertainty, although the individuals in this study perceived illness and physical ailments to be representative of ageing. The study participants highlighted that having an illness or not should not be the major yardstick used to determine the constructs of SA, but that the consequences of facing the onset of health issues have to be managed well. Support and care need to be made available for middle-aged adults and their family members to cope with the ambiguity related to health issues. The major concerns that need to be taken care of in the management of uncertainty include the issue of care provision during old age, the sharing of information on illness management, handling financial pressure, coping with emotional trauma and effectively communicating with family members. Behaviours and outcomes that engender social acceptance, such as nurturing successful children and achieving a certain level of social status and recognition, were also perceived as affecting well-being in old age.

The participants' concerns regarding interventions to improve quality of life during old age should be on the continuity of information and communication related to dealing with the uncertainty involved in old age. Service providers in the health care sector and family development should be trained to identify and differentiate between the actual source of uncertainty faced by the participants and the issues that are experienced by others but which the participants instead perceive to be related to them. Psychosocial support was especially noted as being key to the effective management of uncertainty. The recommendations from these study findings will be discussed in Section 7.3.

## **7.2 Critique of the research**

### **7.2.1 Strengths**

The findings of this study provide some of the first empirical evidence about the reaction to disruptive events and ageing successfully among middle-aged Malaysian adults. The current study has identified some of the crucial actions being taken by middle-aged Malaysian adults for dealing with negative events in the hope of facilitating better ageing. This study emphasises the need for further support that is directed towards enhancing social assistance, with particular reference to family, social and spiritual resources.

The findings of the current research further suggest that the resilience gained by individuals through their normative beliefs and cultural and religious support systems serves to promote better ageing, which in turn contributes to the advancement of theory and further research. As demonstrated by the findings of this study, the ability to cope with adverse events is dependent upon multiple characteristics. Therefore, this study indicates that integrating social resources and personal control beliefs is beneficial in terms of predicting individuals' level of adaptation to adversity in life, which might further affect their ageing experiences.

Furthermore, middle-aged adults have received only limited attention in the burgeoning literature on SA. This could be considered a gap, given that the practices from middle age to old age offer opportunities for exploring social constructs, self-identities and subjectivities. Therefore, the building of an understanding of the changes

that take place in middle age in relation to both health and non-health-related characteristics may be of considerable value in assessing issues linked to ageing and for expanding strategies and interventions to cope with them.

Another useful finding of the present study is that, regardless of the mix of participants, there were a number of common views expressed with regard to ageing successfully. As such, the study presents important information on similarities and differences in SA among both healthy and unhealthy participants with regard to promoting well-being in later life. The study thus makes a clear contribution to useful approaches for the formation of communication methods in the public media and interpersonal or group education sessions within religious and public institutions.

The understanding derived from the current study adds knowledge to the area of social gerontology, health and care, since only a limited amount of knowledge has been available thus far relating to people between the ages of 40 and 59 years. The existing health promotion behaviour considered valuable in Malaysia recommends a balanced diet, prescribes exercise, insists on the cessation of smoking and excessive alcohol intake and suggests practicing good mental health. The present study indicates that these practices would be possible for middle-aged adults with lower uncertainty predicted in the future.

### **7.2.2 Limitations**

While this study eliminates some of the possible descriptions for use with middle-aged adults coping with the uncertainties involved in their future ageing, it also has some limitations and thus the findings need to be interpreted carefully.

Firstly, subjective (self-rated) measures of health were employed instead of clinical measurements among the research participants as indicators for measuring their health status. It should be noted that the participants in this study rated their health status as being relatively high, and this included those with a terminal illness. Although multiple factors contributed to the perceived health status, any future study that uses a subjective health measurement should be supported by clinical measurement in order to provide a more accurate indicator.

The findings might also not be applicable to people with specific illnesses or to individuals reporting a lower subjective health status. For instance, the participants in this study rated their health status along multidimensional levels using collective meanings rather than as a direct change in their physical and/or functional ability. Individuals who report perceiving old age as a reflection of poor health are predicted to engage less in health maintenance behaviour (Stewart et al., 2012). People holding negative stereotypical views about ageing or those who perceive lower self-rated health may therefore view ageing differently.

In addition, the interpretations of the findings in the current study are derived from the data obtained from respondents who are either healthy or who have a terminal or chronic illness. Therefore, the ageing attribute identified in this study might not be strong enough to identify the context of ageing and the concerns of SA among people with different health statuses.

The demographic characteristics of the participants might limit any comparison and transferability of the findings to people in different societies. The trajectory of experiences associated with ageing defined in the present study's findings might be different for people from Western cultures than for those from a non-industrial society. Although the present study may not particularly explore ethnic differences, racial and ethnic background may be important in the experience of ageing (Miner-Rubino et al., 2009).

Further, the present study has not explored gender variability in coping with disruptive events and in perceiving SA. For instance, Calasanti et al. (2013) found that men will tend to use machismo to deal with problems in life. In this study, the male participants expected to be respected by their children and had a desire to seek attention from family members to a greater degree than the female participants. The female participants linked physical declines in health with a reduced ability to perform domestic tasks and prepare meals. Although these differences were encountered, the study did not specifically examine the aspect of gender diversity in the context of the subjective experience of ageing.

The individuals in this study were born between the years 1958 and 1977, a period when Malaysia had just acquired its independence and was going through major economic restructuring. As such, people who were born during this period might display strong ties with family, friends and their community, unique coping strategies and perceived social norms. Most of the study participants were from urban areas, while a few had migrated from rural areas to an urban setting. Helson (1997) has suggested that the term ‘middle age’ could have different meanings, at different times and for different people. Economic differences exist between individuals in urban and rural areas. There are prominent differences between the populations of rural and urban settings in Malaysia. People living in urban settings tend to be in a better financial position compared to individuals who live in rural settings, while people in rural areas have high levels of social capital, notably in the form of participation in political organisations and neighbourhood activities (Selvaratnam & Tin, 2007). Thus, any comparison of the present study’s findings with other populations should take into consideration the age cohorts, experiences and settings that undoubtedly influence the ageing process among those who have lived through different periods of time in comparison to the individuals who participated in this study.

The findings in the present study suggest that the research participants are able to detect and recall changes in their own behaviours and expect to experience ageing in the future. However, the link between their behavioural changes and actual ageing experiences remains a significant component of longitudinal research. Nevertheless, language difference could make it hard to compare and contrast the present study’s findings with those of other studies that have been conducted in countries with different languages. Cultural variations in communication may especially impact upon the responses given by participants to open-ended question

### **7.3 Recommendations for future research**

Individual’s perceptions of ageing could be related to a stereotypical view of ageing, their substantial behaviours or both. Thus, investigations about ageing successfully may need to be conducted among people with different perceptions of self-rated health status, either negative or positive subjective health.

It is notable that cultural construction in relation to the ageing process differs from one society to another around the world. Cultural comparisons also necessitate an examination of how cultural norms regarding interpersonal relationships, work patterns, religion and dominant cultural values influence these processes (Jackson, 2002) (see Section 7.2.2). In order to form meaningful generalisations, it may be necessary to consider cross-cultural differences with the recruitment of a more diverse sample.

It is also recommended for a future study to look at the management of uncertainty for achieving SA, in particular at the challenges encountered during middle age using a longitudinal design to permit the consideration of a change in the strategies used to deal with negative events. In addition, a longitudinal study has the ability to identify and relate SA, and to further define its exposure with regard to the presence of uncertain events, its timing and chronicity (Caruana et al., 2015).

## **7.4 Implications of this study**

The population of Malaysia is predicted to significantly increase in the future. This phenomenon of growth in the proportion of older people supports the importance of forming initiatives that are focused on care of the older people through public policies, practices and education and to support adults in the process of ageing successfully. Therefore, the current study contributes to new knowledge related to understanding the process of ageing in this community and the initiatives taken by people to age successfully. While the current literature on SA acknowledges that preparation for later life should develop from middle age, there is little in the way of lay perspectives, in which research among people from a Malaysian background is lacking. The literature search revealed an absence of any previous exploration of this issue. This section will thus delineate the contribution of this study in terms of its implications for the model of SA and the data for guiding decision-making in formulating cohesive policies and practices relating to the needs of the Malaysian older population.

### **7.4.1 Contribution to existing theory of ageing successfully**

The findings of the present study support an interrelationship between the biological, psychological, family relationship, social support and spiritual elements of the existing

models of successful ageing. This study confirms that the determinants of SA are achieved through collective actions rather than through individual motivations, particularly in relation to this studied population. The findings have also identified that disruption in middle age needs to be adequately addressed as part of the ageing process and should be incorporated into study of the SA model. The findings of the present research have also highlighted the core determinants that influence uncertainty, which interrupts the experience of SA in later life. The dominance of those coping strategies that have been adopted by the participants to address the uncertainty that is relevant to the study population has also been located.

The study contributes some significant new insights about the experience of SA, particularly with regard to middle-aged adults. The challenges experienced by people in middle age have thus far been acknowledged in the past literature insofar as relating only to a midlife crisis, but in the present study these challenges have been further developed as a pivotal factor that influences the circumstances of SA. Moreover, the grounded theory method used in this study highlights the uncertainty that arises due to the consequences of existing disruptive events being pervasive problems that influence people's quality of life during the later stages of life. The findings also revealed that health was only a marginal concern among this group, which is in contrast to the biomedical model of SA. Both of these results warrant further exploration. The study also indicated the complexity of social norms and their relative impact on the development of coping strategies by the middle-aged adults. On the whole, this study has served to extend the current understanding of the nature of advancement of the 'self' in the face of adversity.

The Theory of Planned Behaviour (TPB) might influence the analysis of the findings, though it formed part of the researcher's background knowledge and shaped the data that was being analysed. The TPB was drawn on due to the need to explore individuals' beliefs, attitudes and perceived behaviours related to ageing and what the participants see as barriers to taking actions that might motivate SA. The current study highlights that individuals' own past experiences and the experiences of other individuals significantly influence their intentions with regard to taking action. As such, the TPB may be beneficial in regard to the inclusion of the construct of 'Past Experience'

(Sommer, 2011), especially in relation to a study that aims at understanding the development of intentions during individuals' future life. According to the TBP, behaviour is influenced by attitudes and perceived behavioural control; the present study has drawn attention to a sudden disruptive event that could act as a modifier of intended behaviour. As such, these two components, 'Past Experiences' and 'Disruptive Events', are likely to be considered when attempting to explain variations in intention.

#### **7.4.2 Contribution to policy**

The Malaysian Minimum Retirement Age Act set the retirement age for public and private sector employees as 60 years of age in 2014. This remains below the retirement age of 65 years that is in place in most developed countries. However, in this study, the participants felt that the onset of old age begins at an age below 60 years. The view of the ageing period was identified as being earlier than the biological age, particularly among those participants who had health issues. Further investigation is thus required on a broader ageing perspective among middle-aged people with health issues.

The study shows that the process of ageing identity begins to be developed when a person is 40 years of age and above. Therefore, the timely identification of an ageing process needs to be addressed through a national policy for the elderly. This study agrees that optimal physical and psychological development in later life is highly dependent on the experiences of an individual during their middle age (Willis et al., 2010). At present, Malaysia has a unique national policy called 'National Planning for Golden People' that focuses on older adults who are above 60 years of age. This 'National Planning for Golden People' is developed and revised every five years under the Malaysian Plan (*Rancangan Malaysia*), which is a comprehensive blueprint prepared every five years by the Economic Unit (EPU) of the Prime Minister's Department with the Cabinet of Malaysia (see Chapter 2, Section 2.6).

The current study has revealed inadequate funding for older population who face disruptive events such as health issues and reduced support from their children. Therefore, health care and social security schemes should be enhanced to ensure that adults receive incentives or special funding, especially for adults with a terminal

illness, to prevent them from falling into poverty. A study of intergenerational issues from the perspectives of parents and children has not been an aim of this research. However, the data from this study do support the establishment of extensive intergenerational programmes aimed at fostering the relationship between young people and old-age adults. The data from this study provide evidence that supports the aims of the National Family Policy; to advocate the concept of family well-being based on family values and equity, and to impart positive integration from generation to generation. The efforts to support familial relationships need to be initiated by both the government and through collaboration with the private sector, NGOs and religious institutions.

The findings of the study also contribute to public health initiatives aimed at health promotion by highlighting the possibility of achieving SA while also managing acute or chronic health problems. Many of the participants in this study manage their chronic illness actively, taking the effort to live productive lives, and they consider themselves to be ageing successfully. Knowledge of the participants' personal beliefs with regard to SA, along with the processes and strategies they employ, is significant for enhancing health care service, especially in terms of providing individually appropriate interventions. Policy and practice in public health interventions needs to reflect diversity and take into account the impact of social norms in the present community, as the current study highlights a connection between social norms and the notion of disruptive events.

### **7.4.3 Contribution to education and practice**

The aim of education and promotional activities should be to enable middle-aged adults to increase their resilience power and self-sustainability with regard to practicing successful ageing. Health promotion activities, in particular, must focus on enabling middle-aged individuals to take control and responsibility for their health and practice a healthy lifestyle.

The element of successful ageing should be incorporated into the integrated care provided in clinics and hospitals for middle aged patients with chronic illnesses in order for them to build the capacity to manage the uncertainty faced during middle

age. Capacity building for health care professionals and paramedics therefore should therefore empower them with training and resources to manage patients with integrated services.

Meanwhile, the focus of interventions for successful ageing should go beyond individual behaviour and towards a wide range of family, social and environmental interventions. Awareness of lifelong healthy lifestyles for a successful ageing population should be disseminated via conventional and modern media; community empowerment activities and capacity building and through smart partnerships with NGO's promoting successful ageing, ministries under the Secretariat for the National Advisory and the Consultative Council for Older Persons plus other agencies with similar interest.

## **7.5 Final statement**

Recognition of the need to identify ageing among older people has grown in Malaysia over recent years, with having been a marked increase in the amount of research conducted in this area. Attention to the ageing process should strongly emphasise the resources and strategies that increase certainty in ageing experiences. National programmes should be considered in relation to behavioural change and other health promotion in middle age in order to enable sustained quality of life at older ages. The development of an effective national framework based on what is needed by the people will enable individuals to make greater contributions to society through having the capacity to support their own needs, their families and to participate in productive action. This study has thus been timely and is important in terms of bringing attention to a model of SA that is culturally appropriate to the Malaysian population.

## Appendices

Appendix 1 – A little more about me, taken from the blog  
<https://wisdomforoldfriends.wordpress.com/author/vanithasubramaniam/>



Some of my present-day friends and acquaintances might say that this dark-skinned, cute-but-mischievous little girl with curly hair bears a close resemblance to me, and their assumption would be correct! But I bet they would still have their doubts if it really was me because of the continuous transitions that I have undergone up to the present day.

In this photo, I certainly look a bit stressed out for some unknown reason. Was it because I did not know what to do standing there? Was I afraid of the lights that were glaring at me and the camera that was pointing in my direction? Was I worried that my parents might leave me there and go back home? Or was it because I was compelled to pose like a model for an unknown photographer? Whatever the reasons, I do not even have the faintest memory of them today, yet this most splendid and priceless photograph is so very special to me as it is the only toddler photograph, I have that reminds me of my innocent childhood looks. It is even more treasured as I am the only

one in my family to have a picture like this. During the early 1970s, after my parents migrated from India to Malaysia, having us photographed in a studio was considered a luxury. Keeping up with life ‘just enough’ financially was by itself a great challenge for most migrants like us. So, I am sincerely grateful to my parents for capturing these precious moments that I will be able to cherish for many more years to come.

After completing my primary education at an Indian vernacular school where the curriculum was taught only in the Tamil dialect, my mother tongue, I had to confront a bigger and worse problem that was awaiting me upon my enrolment at secondary school. The curriculum in my secondary school was taught in Malaysia’s national language – Malay. As my parents were illiterate, they were neither able to coach me in my studies nor afford the extra money for tuition fees. They had five children to raise and had immense responsibilities to provide their food, shelter, clothes and other fundamental necessities. Needless to say, with my father being the sole breadwinner, all of these were very difficult. And so, as you might imagine, reaching my current position of pursuing my phd study at an institution of international repute was not an easy task either.



**Photo taken at my first international U21 conference in New Zealand as a presenter.**

Amidst the economic hurdles and financial limitations, I realised that education was my only option for being able to break away from those barriers and to progress in life, and to some extent, a possible way of breaking the gender inequality faced by the women in my society. My mother barely finished her primary education during her

schooling time, since having access to education or pursuing a career was not considered significant for women at the time.

I can confidently say that I have overcome the problems that any migrant family in Malaysia would have faced, especially the language barrier (to some extent), and have progressed beyond my comfort zone to where I am now. Yet the fight certainly does not end there! Even now, at the age of 40, I still believe that education is the only opportunity to uplift one's life, and that was the prime reason behind me striving for an opportunity and discovering the important milestone of pursuing a phd programme from the University of Edinburgh in this beautiful land of Scotland.

Now, however, shifting our focus back to the toddler in the photo, she seems oblivious to the sophistication of the world she is living in, of course due to the fact that it would be difficult for a child of her age to understand it. Fairly, our knowledge of the world we live in is shaped by our attitude, the decisions we make and the actions we perform. A few days ago, a friend of mine asked me how I would like to see myself 10 years from now. And I am clear in my answer that I see myself as an advocate for a positive ageing of the society I am living in - and for it this research would serve as a starting point.

## Appendix 2 – Ethical Approval from the School of Health Social Science, University of Edinburgh



SCHOOL of HEALTH IN SOCIAL SCIENCE  
CLINICAL AND HEALTH PSYCHOLOGY

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Vanitha Subramaniam  
PhD Student  
School of Health in Social Science  
University of Edinburgh

01 April 2015

Dear Vanitha,

### Application for Level 2/3 Approval

**Project Title:** The perspective of 'successful aging' among Malaysian middle aged adults: A study of grounded theory

**Academic Supervisor:** Charlotte Clarke

Thank you for submitting the above research project for review by the Department of Clinical and Health Psychology Ethics Research Panel. I can confirm that the submission has been independently reviewed and was approved on the 30<sup>th</sup> March 2015.

Should there be any change to the research protocol it is important that you alert us to this as this may necessitate further review.

Yours sincerely,

Kirsty Gardner  
Administrator  
Clinical Psychology

## Appendix 3 – Ethical approval letter from the Institute for Health Behavioural Research (IHBR)

**NATIONAL INSTITUTES OF HEALTH (NIH) RECOMMENDATION FOR THE  
CONDUCT OF RESEARCH IN THE MINISTRY OF HEALTH MALAYSIA  
PENGESAHAN INSTITUSI KEBANGSAAN NEGARA UNTUK MENJALANKAN  
PENYELIDIKAN DI KEMENTERIAN KESIHATAN**

This is an auto-generated document. It is issued by one of the research institute under the National Institutes of Health (NIH). The institutes as follows: Institute for Medical Research (IMR), Institute for Public Health (IPH), Clinical research centre (CRC), Institute for health Management (IHM), Institute for Health System Research (IHSR) and Institute for Health Behavioural Research (IHBR).

*Dokumen ini adalah cetakan berkomputer. Borang ini dikeluarkan oleh salah satu institusi dibawah National Institutes of Health (NIH) iaitu Institut Penyelidikan Perubatan (IMR), Institut Kesihatan Umum (IKU), Pusat Penyelidikan Klinikal (CRC), Institut Pengurusan Kesihatan (IPK), Institut Pengurusan Sistem Kesihatan (IPSK) dan Institut Penyelidikan Tingkahlaku Kesihatan (IPTK).*

<b>Unique NMRR</b> <i>[Nombor Pendaftaran]</i>	NMRR-14-1409-22872
<b>Research Title</b> <i>[Tajuk]</i>	The perspective of successful ageing among Malaysian middle aged adults: A study of grounded theory
<b>Protocol Number if</b> <i>[Nombor Protokol jika ada]</i>	

#	<b>Investigator Name</b> <i>[Nama Penyelidikan]</i>	<b>Institution Name</b> <i>[Nama Institusi]</i>
1	Vanitha A/P Subramaniam	

I have reviewed the above titled research, and has recommended to MREC\* for its decision.

*Saya telah menyemak penyelidikan yang bertajuk diatas, dan telah disyorkan untuk MREC bagi keputusannya.*

<b>Name of Director</b> <i>[Nama pengarah]</i>	Pn. Siti Sa'edieh Hassan Nudin
<b>NIH Institute (IMR, IPH, CRC, IHM, IHSR, IHBR)</b> <i>[Nama institusi di bawah NIH]</i>	Institute for Health Behavioural Research (IHBR)
<b>Signature &amp; Official Stamp</b> <i>[Tandatangan dan Cop Rasmi]</i>	
<b>Date</b> <i>[Tarikh]</i>	23-02-2015

\*Final approval is pending MREC decision.

## Appendix 4 – Ethical approval from the Medical Research & Ethics Committee (MERC)



### JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN

(Medical Research & Ethics Committee)

KEMENTERIAN KESIHATAN MALAYSIA

d/a Institut Pengurusan Kesihatan

Jalan Rumah Sakit, Bangsar

59000 Kuala Lumpur

Tel : 03 2282 0491

Faks: 03 2282 8072 / 03 2282 0015

Ruj. Kami : (7) KKM/NIHSEC/P15-217

Tarikh : 19hb Mac 2015

**VANITHA A/P SUBRAMANIAM**  
HOSPITAL SULTAN ISMAIL

Tuan/Puan,

**NMRR-14-1409-22872 (IIR)**

**The perspective of successful ageing among Malaysian middle aged adults: A study of grounded theory**

**Lokasi Kajian:**

Bil	Lokasi Kajian
1	Bahagian Pembangunan Kesihatan Keluarga, Kementerian Kesihatan
2	Bahagian Pendidikan Kesihatan, Kementerian Kesihatan
3	Hospital Sultan Ismail
4	Klinik Kesihatan Johor Baru
5	Klinik Kesihatan Sultan Ismail

Dengan hormatnya perkara di atas adalah dirujuk.

2. Jawatankuasa Etika & Penyelidikan Perubatan (JEPP), Kementerian Kesihatan Malaysia (KKM) tiada halangan dari segi etika ke atas pelaksanaan kajian tersebut. JEPP mengambil maklum bahawa kajian tersebut tidak mempunyai intervensi klinikal ke atas subjek dan hanya menggunakan kaedah tamuduga sahaja untuk mengumpul data kajian.

3. Segala rekod dan data subjek adalah SULIT dan hanya digunakan untuk tujuan kajian ini dan semua isu serta prosedur mengenai *data confidentiality* mesti dipatuhi. Kebenaran daripada Pegawai Kesihatan Daerah/Pengarah Hospital dan Ketua-Ketua Jabatan atau pegawai yang bertanggung jawab di setiap lokasi kajian di mana kajian akan dijalankan mesti diperolehi sebelum kajian dijalankan. Tuan/Puan perlu akur dan mematuhi keputusan tersebut.

4. Adalah dimaklumkan bahawa kelulusan ini adalah sah sehingga **19hb Mac 2016**. Tuan/Puan perlu menghantar dokumen-dokumen seperti berikut selepas mendapat kelulusan etika. Borang-borang berkaitan boleh dimuat turun daripada laman web MREC (<http://www.nih.gov.my/mrec>).

- I. 'Continuing Review Form' setewat-lawatnya 2 bulan sebelum tamat tempoh kelulusan ini bagi memperbaharui kelulusan etika.
- II. Laporan tamat kajian pada penghujung kajian.
- III. Laporan mengenai "All adverse events, both serious and unexpected" i/Protocol Deviation atau Violation kepada Jawatankuasa Etika & Penyelidikan Perubatan, KKM jika berkenaan.
- IV. Memaklumkan jika terdapat pindaan keatas sebarang dokumen kajian

5. Sila ambil maklum bahawa sebarang usuan surat-menyurat berkaitan dengan penyelidikan ini haruslah dinyatakan nombor rujukan surat ini untuk melicinkan usuan yang berkaitan.

Sekian terima kasih.

**BERKHIDMAT UNTUK NEGARA**

Saya yang menurut perintah,



(DATO' DR CHANG KIAN MENG)  
Pengerusi  
Jawatankuasa Etika & Penyelidikan Perubatan  
Kementerian Kesihatan Malaysia

**Pengarah,  
Hospital Sultan Ismail**

**Pusat Penyelidikan Klinikal  
Hospital Sultan Ismail**

**Pegawai Kesihatan  
Klinik Kesihatan Johor Baru**

**Pegawai Kesihatan  
Klinik Kesihatan Sultan Ismail**



**Appendix 6- Approval letter from the hospital director of HSI to obtain access to participants' (with chronic/terminal disease) medical record on their disease diagnosis, behavioural modification and disease management.**

Pengarah  
Hospital Sultan Ismail,  
Jalan Persiaran Mutiara Emas Utama,  
Taman Mount Austin,  
81000 Johor Bahru  
Johor Darul Ta'zim

*Kuaha*  
*Johor Bahru*  
*Sz. P. Pembata*  
28hb Jun 2016  
*30/6/16*

**Kajian Perspektif mengenai 'keusiaan yang sempurna' di kalangan orang dewasa di Johor Bahru**

Adalah saya merujuk kepada perkara di atas.

2. Sepertimana yang diketahui oleh pihak Tuan, saya sedang menjalankan kajian berkaitan "Perspektif mengenai 'keusiaan yang sempurna' di kalangan orang dewasa" di negeri Johor di Hospital Sultan Ismail, Johor Bahru selari dengan keperluan latihan Ph.D yang dihadiri di *University of Edinburgh, United Kingdom*.

3. Kajian ini menggunakan kaedah 'Grounded Theory' dan bertujuan untuk menghasilkan model keusiaan yang sempurna, khasnya bagi kumpulan orang dewasa berumur di antara 40 tahun sehingga 60 tahun. Selain itu, kajian ini juga diharap dapat menelaami faktor-faktor penyumbang keusiaan yang sempurna bagi kumpulan masyarakat yang menderita penyakit mengancam nyawa dan juga untuk memahami tingkahlaku kesihatan mereka.

4. Selubungan dengan itu, saya memerlukan beberapa maklumat berkaitan peserta kajian yang juga merupakan pesakit di Klinik Berhenti Merokok dan pesakit dari Unit Rawatan Dialisis, Hospital Sultan Ismail, Johor Bahru. Maklumat yang diperlukan adalah seperti berikut:

- a) Maklumat bacaan tinggi dan berat terkini pesakit
- b) Diagnosis penyakit
- c) Kecepatan kemasukan wad dari tahun 2014 sehingga Jun 2016
- d) Status pengurusan penyakit oleh pesakit dan
- e) Perubahan tingkahlaku kesihatan yang dicapai oleh mereka.
- f) Kehadiran pesakit dalam lingkungan umur 40-60 tahun di HSIB dan jumlah pesakit mengikut 10 penyakit utama

3. Bagi menjamin kerahsiaan pesakit, nama mereka tidak disertakan bersama surat ini, tetapi senarai pesakit yang terlibat di dalam kajian ini adalah terdapat di simpanan Pegawai kesihatan Klinik Sihat- Dr Suriya bte Marsom dan juga fasilitator kajian ini SN Nur Fara Zura bte Razuli, Klinik Sihat.

4. Bersama surat ini sesalinan surat kelulusan etika kajian daripada NMRR dan 'University of Edinburgh'; surat kebenaran untuk melakukan kajian daripada Jabatan Kesihatan Negeri Johor disertakan bersama. Sekiranya, memerlukan maklumat tambahan berkaitan kajian ini pihak Tuan/Puan boleh menghubungi saya di talian 011-16203875. Sekian, terima kasih.

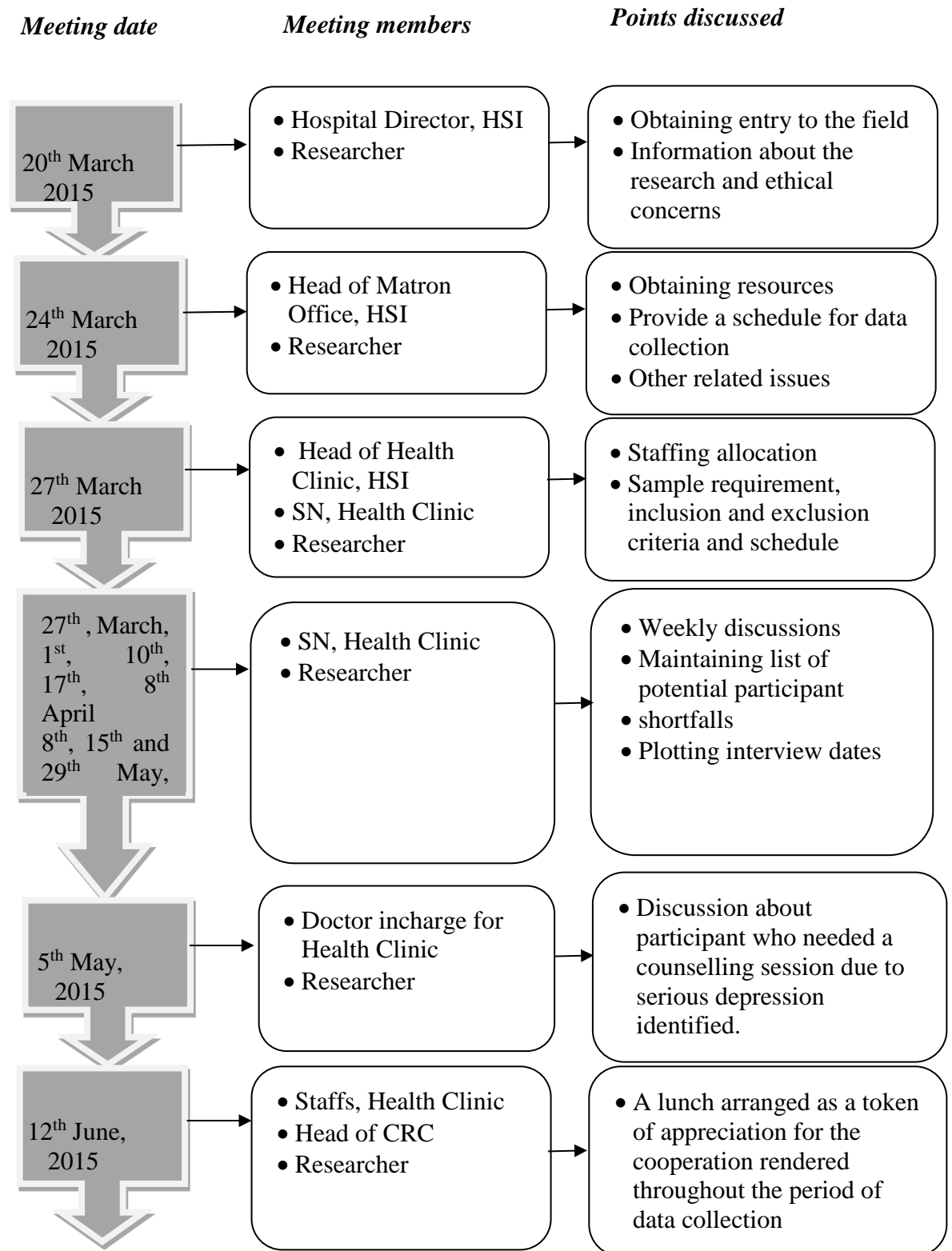
Yang benar,  
*Hamid*  
Valitha Subramaniam  
Pegawai Pencerahan Kesihatan S48 (Dalam Latihan)  
Kementerian Kesihatan Malaysia



m/s: 1/1

*Fait Hassan*

**Appendix 7 – Flowchart: Details of the meetings conducted between the investigator and relevant authority at initial data collection**



## **Appendix 8: Guidance notes for gatekeeper (English)**

### **Research title:**

The perspective of successful ageing among middle-aged Malaysian adults: A grounded theory approach

### **Research objective:**

The objective of this study is to understand how both healthy individuals and individuals with chronic illness in middle age perceive ageing and how they cope with factors that affect their ageing process.

### **Communication note while talking with the potential research participants over the phone:**

Before contacting the potential participant please make sure the notes on the relevant information are referenced and you might want to follow the actions stated below:

1. Greet the potential participant
2. Provide information about the caller and the purpose of the call
3. Describe the purpose of the study and why they have been selected (please refer to the study information sheet)
4. Provide information about the researcher if needed (background of the researcher):
  - a. The researcher is a former staff member at the Sultan Ismail hospital.
  - b. She is currently studying at Edinburgh University in the United Kingdom and the research is being conducted as part of her PhD study.

If the potential participant agrees to participate in this study, please:

1. Thank them for their consent to participate in this study
2. Discuss the interview date
3. Give a reminder call at least 3 days before the date of the interview
4. Provide the clinic number and personal phone number of the researcher in case they need to contact the clinic/researcher for additional information or wish to change the interview date.

If the potential participant declines to participate in this study, please:

1. Thank them for the time spent
2. Ask if they would be comfortable with the researcher of this study contacting them personally to understand the reason or provide further information on the research conducted
3. Provide the clinic number and personal phone number of the researcher to the participant in case they change their mind and decide to participate in the study.

## **Appendix 9: Guidance notes for gatekeeper (Malay language)**

### **Tajuk kajian:**

Kajian berkaitan perspektif 'berusia dengan sempurna' menggunakan pendekatan 'grounded theory' di kalangan orang dewasa pertengahan usia di Malaysia

### **Tujuan kajian:**

Adalah untuk mengetahui bagaimana orang dewasa di pertengahan usia yang sihat dan mereka yang mempunyai penyakit kronik menghadapi keusiaan dan dan faktor mempengaruhi keusiaan mereka dan perancangan untuk menghadapinya.

Nota komunikasi dengan peserta apabila menghubungi mereka di telefon:

Sebelum menghubungi peserta berpotensi sila pastikan nota informasi berkaitan kajian yang dirujuk. Semasa berkomunikasi dengan peserta berpotensi :

1. Mengucapkan salam kepada peserta
2. Berikan maklumat berkaitan pemanggil dan tujuan panggilan
3. Menerangkan tujuan kajian dan mengapa mereka dipilih (sila rujuk kepada informasi kajian)
4. Informasi berkaitan pengkaji
  - a. Pengkaji merupakan bekas staf di hospital Sultan Ismail.
  - b. Beliau kini sedang melanjutkan pelajaran di University Edinburgh di United Kingdom.

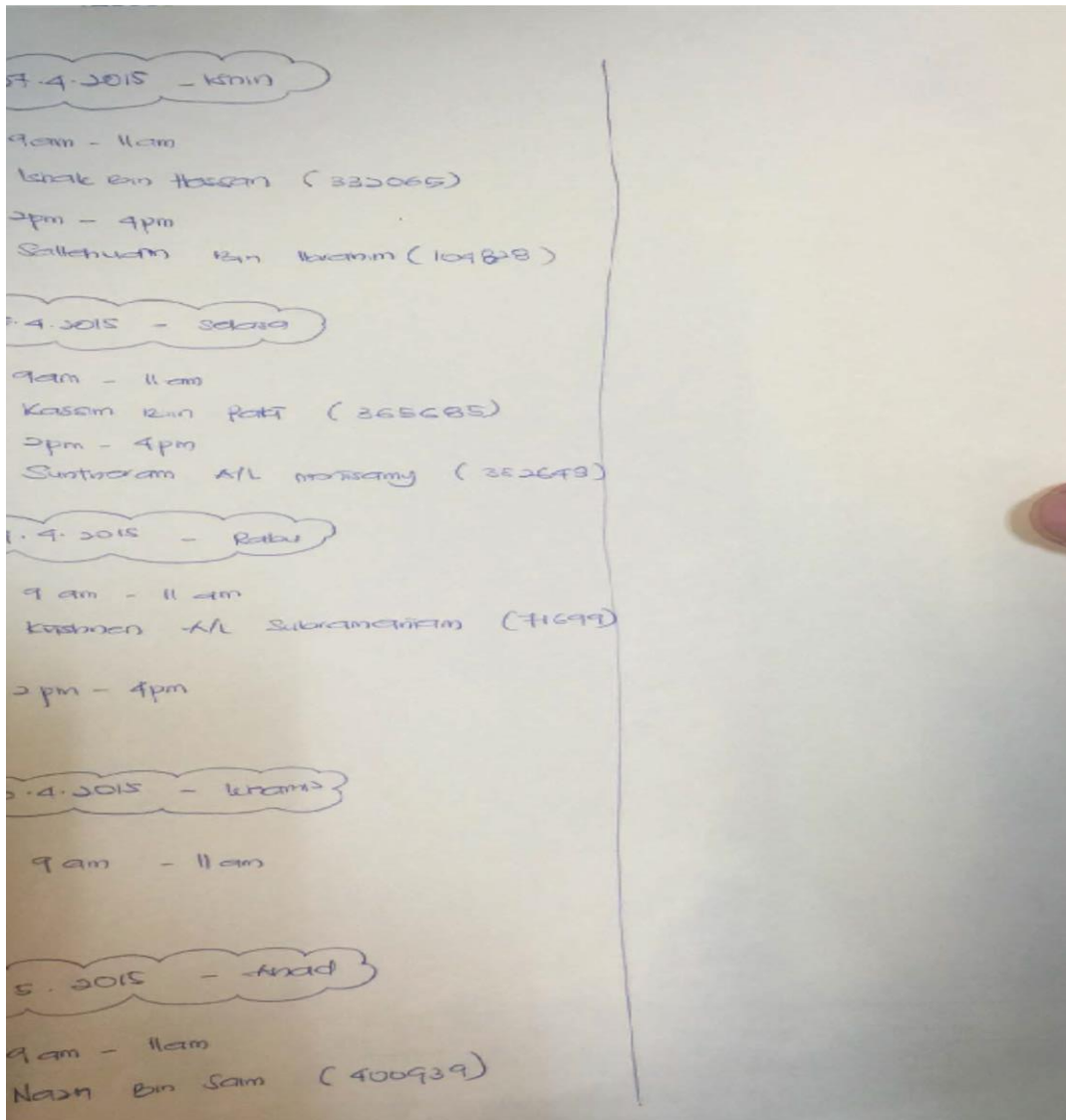
Sekiranya bersetuju untuk menyertai kajian ini sila:

1. Mengucapkan terima kasih di atas persetujuan mereka untuk menyertai kajian ini
2. Bincang dengan peserta tarikh temuduga
3. Beri panggilan sekurang-kurangnya 3 hari sebelum tarikh temuduga
4. Berikan nombor klinik dan no telefon peribadi pengkaji kepada peserta jika mereka perlu menghubungi klinik/pengkaji untuk mendapatkan maklumat tambahan atau ingin menukar tarikh temujiani.

Sekiranya tidak bersetuju menyertai kajian ini sila:

1. Mengucapkan terima kasih di atas masa yang diluankan
2. Tanya kebenaran jika pengkaji sendiri menghubungi mereka untuk memberi maklumat lanjut berkaitan kajian yang dijalankan
3. Berikan nombor klinik dan no telefon peribadi pengkaji kepada peserta jika mereka mengubah fikiran untuk menyertai kajian

**Appendix 10 – An example of an interview schedule kept in a special recording book by the gatekeeper**



## **Appendix 11: Information Sheet (English)**

### **Participant (Middle-Aged Adult) Information Sheet**

*This form is bilingual, please obtain a Malay version if necessary.  
Maklumat kajian ini adalah dwi Bahasa, sila dapatkan versi Bahasa Melayu jika*

#### **Study title:**

The perspective of successful ageing among middle-aged Malaysian adults: A grounded theory approach

#### **Introduction**

Dato’/Dr/Mr/Madam: You are invited to participate in a research study looking at the perspective of successful ageing among middle-aged Malaysian adults. It is important for you to understand why the research is being carried out and what it entails. As such, please take time to **read** the following information carefully. This information sheet is a written acknowledgement of the study conducted in addition to the explanation given by the investigator. Please ask if there is anything that is not clear or if you would like further information.

#### **Information on the person conducting the study**

The study is being conducted by Vanitha Subramaniam, a Health Education Officer employed by the Ministry of Health Malaysia and currently pursuing her PhD at the University of Edinburgh, United Kingdom. This study is being conducted as part of her PhD programme.

#### **The purpose of the study**

The purpose of this study is to understand the perceptions of middle-aged people in Malaysia with regard to ageing and to understand their context of ‘ageing successfully’. The researcher wants to know how you see yourself ageing and to learn about factors such as attitude, culture, norms and lifestyle that underpin the process. We are aware that we have a steadily ageing population in Malaysia, and we will therefore eventually become a nation with higher older people in the future. Indeed, this study will be helpful to understand the insight of this phenomenon for both educational and practice settings and to fill the gap in the literature on the perspectives on successful ageing among middle-aged adults with a Malaysian heritage.

#### **The procedures of the study**

Adults aged between 40 and 60 from the ‘Mamoodiah community clinic’ in Johor Bahru will be recruited to participate in face-to-face interviews on several occasions until such time as all of the required information has been gained. In the interviews,

open-ended questions will be asked about your experiences and feelings about getting older. Participants will be free to decline to answer any particular questions that may make them uncomfortable. Data collection will involve interviews, an audio tape recording and observation field notes. The participants will be able to ask for an interpreter if necessary. Each interview session is expected to last for approximately an hour and a half, and the venue and time can be arranged according to your convenience. Data will be collected over a period of 12 months, which will run from the time of the first interview session conducted.

### **Potential Risks**

There is no significant risk anticipated. However, there could be unforeseen risks such as embarrassment in answering personal questions or the possibility of an individual becoming upset when remembering things from their life or thinking about getting older. In rare cases, it is possible that your participation in the interview could cause fatigue. At any point, if you require help or assistance, we can arrange for a staff member from the clinic to assist you.

### **Benefits**

The possible benefits of this study include a chance to share your opinions and ideas. Although the information collected may not benefit you directly, the information gleaned in this study may be helpful to others involved in policy making and health education and to those providing services to middle-aged and older people. This information may assist in the later development of new strategies promoting the successful ageing of middle-aged Malaysian adults.

### **Appreciation**

Participants who attend a session and complete the interview will receive an RM5 gift card that can be used in any Jusco supermarket in acknowledgement of the time spent.

### **Confidentiality**

All information obtained about yourself and your interview details will be kept confidentially. Tape recordings will be destroyed one year after the completion of this study while the ensuing records of your interviews will be stored in a locked filing cabinet in a secure area at the School of Health in Social Science, University Edinburgh. The participants' answers will also be kept on a password-protected computer. All data collected will be coded without your name, and the consent forms containing your names will be kept separate from all other data. If the results of this study are published, your name will not be made public. Any information about you which I submit will also have your name and address removed so that your identity is not recognised.

## **Voluntary Participation**

Taking part in this study is voluntary. You may choose not to take part at all. Although you have opted to participate in this study, you may elect to end your participation at any time. If you decide not to be in this study or if you end your involvement at any time, you will not lose any benefits or health care for which you may qualify. If you do decide to take part in the study, you will be given this information sheet and a consent form to sign.

If you choose to drop out of the study prior to completion of the data collection process, partially completed surveys will be destroyed in the presence of the participant.

## **Research Subject's Rights, Questions, Concerns and Complaints**

If you have any concerns or complaints about the study or the researcher, please contact my supervisors (Professor Charlotte Clarke and Dr Sarah Ryanas), whose details are given at the end of this information sheet.

## **Reviewer of the study**

This study has been reviewed by:

1. Research Ethics Committee of the School of Health in Social Science, University of Edinburgh.
2. Malaysian National Research Registry (NMRR), Ministry of Health Malaysia.
3. Institute for Health Behavioural Research (IHBR), Malaysia.

## Contact for further information

If you have any concerns about the study, you may contact the individuals listed below:

- 1) Ms Vanitha Subramaniam  
Postgraduate student (Full-time PhD student) and the investigator of this study  
School of Health in Social Science  
University of Edinburgh  
Teviot Place, Edinburgh  
EH8 9AG  
Phone: +44(0)131 651 6671(UK)  
Phone: 0126245939 (Malaysia)
- 2) Professor Charlotte Clarke  
Head of School  
School of Health in Social Science  
Doorway 6, Medical Quad, Teviot Place  
Tel : 0131 650 4327  
Email: [Charlotte.Clarke@ed.ac.uk](mailto:Charlotte.Clarke@ed.ac.uk)
- 3) Dr Sarah J. Ryanas  
Teaching Fellow in Nursing Studies  
Room 1M6, Doorway 6, Medical Quad, Teviot Place  
Tel : +44 (0) 01316503882  
Email: [sarah.rhynas@ed.ac.uk](mailto:sarah.rhynas@ed.ac.uk)
- 4) Hajah Faizah bte Jurimi  
Head of Health Promotion  
Johor state Health Department  
Tingkat 3 & 4, Blok B, Wisma Persekutuan  
Jalan Air Molek, 80590 Johor Bahru  
Phone number: 07-3565000  
Email address: [faizahupk@yahoo.com.my](mailto:faizahupk@yahoo.com.my)
- 5) Siti Sa'adiyah Hassan Nuddin,  
Director  
Institute for Health Behavioural Research (IHBR), Malaysia  
Phone: 03-20821400 (Office)

Please retain this information sheet and a copy of the signed consent form. Thank you for reading this sheet.

## Appendix 12: Information Sheet (Malay language)

### Borang Maklumat Kajian Responden

Maklumat kajian ini adalah dwi Bahasa, sila dapatkan versi Bahasa Inggeris, jika perlu.

#### Tajuk Kajian:

Perspektif ‘berusia secara sihat’ menggunakan pendekatan ‘*grounded theory*’ di kalangan orang dewasa pertengahan usia di Malaysia

#### Pengenalan

Dato’/Dr/Tuan/Puan: Anda dipilih untuk menyertai kajian berkenaan perspektif ‘berusia secara sihat’ di kalangan orang dewasa di pertengahan usia di Malaysia. Adalah sangat penting bagi anda memahami isi kandungan kajian ini sebelum mengambil keputusan untuk menyertainya, oleh yang demikian anda dinasihatkan untuk **membaca** borang maklumat ini. Borang maklumat kajian ini adalah maklumat rasmi berkaitan kajian ini, selain keterangan yang akan disampaikan oleh penyelidik. Sekiranya maklumat terkandung di borang ini tidak jelas atau memerlukan maklumat tambahan, sila bertanya dengan penyelidik kajian. Anda dibenarkan untuk mengambil masa untuk berfikir sebelum mengambil **keputusan** samada terlibat di dalam kajian ini.

#### Maklumat berkaitan penyelidik

Kajian ini dikendalikan oleh Vanitha Subramaniam, Pegawai Penerangan Kesihatan dari Kementerian Kesihatan Malaysia dan beliau sedang mengikuti program falsafah kedoktoran di Universiti Edinburgh, United Kingdom. Kajian ini merupakan keperluan terpenting pengajian beliau.

#### Tujuan kajian

Tujuan kajian ini adalah untuk mengetahui bagaimana orang dewasa di pertengahan umur melihat keusiaan dan juga memahami konteks ‘berusia dengan sihat’ di kalangan mereka. Penyelidik juga ingin mengetahui bagaimana anda melihat diri anda dalam kaca keusiaan serta bagaimana faktor-faktor seperti budaya, norma masyarakat dan gaya hidup mempengaruhi proses keusiaan. Sebagaimana yang diketahui, bilangan warga emas di Malaysia sedang meningkat dan negara kita akan disenaraikan sebagai negara berpopulasi masyarakat berusia di dunia di masa hadapan. Oleh yang demikian, kajian ini membantu fenomena ini diselidik secara terperinci; hasil kajian ini akan digunakan oleh pengajar dan pengamal kesihatan di lapangan serta menjawab kepincangan maklumat yang terdapat berkaitan tingkahlaku berkaitan keusian di kalangan yang orang dewasa pertengahan umur di Malaysia.

#### Prosedur kajian

Orang dewasa lingkungan umur di antara 40 dan 60 dari klinik kesihatan Mamoodiah di Johor Bahru akan dipilih untuk menyertai beberapa sesi temuramah sehingga semua maklumat dikehendaki diperolehi. Soalan-soalan berbentuk 'temuramah' berkaitan pengalaman dan perasaan berkaitan akan ditanya. Anda boleh menolak daripada menjawab sebarang soalan yang menimbulkan ketidakselesaan. Perbualan temuramah akan direkod dan juga nota akan diambil di lapangan bagi tujuan pembelajaran. Setiap sesi temuramah diharap tamat di antara sejam tiga puluh minit. Tempat dan masa temuramah boleh dirunding dan ditetapkan mengikut keselesaan anda. Anda juga boleh memohon untuk khidmat jurubahasa. Data kajian ini akan dipungut selama 12 bulan bermula dari sesi temuramah yang pertama.

### **Jangkaan risiko**

Tiada sebarang risiko langsung yang dijangka. Walaubagai manapun, kemungkinan anda merasa tidak selesa untuk menjawab soalan peribadi, merasa sedih mengimbas kembali pengalaman lampau atau sedih melihat diri menjadi 'tua'. Sekiranya keadaan ini berlaku, kami boleh menguruskan bantuan khidmat nasihat daripada anggota klinik.

### **Manfaat kajian**

Anda dapat berkongsi pendapat dan idea. Walaupun ia tidak membawa manfaat secara langsung kepada diri tuan/puan, tetapi ia amat berguna kepada orang lain seperti pengubal polisi dan juga penyampai perkhidmatan golongan dewasa dan warga tua. Hasil kajian ini akan digunakan bagi menyediakan pendekatan baru mempromosikan keusiaan secara sihat di kalangan orang dewasa pertengahan umur.

### **Penghargaan**

Baucer bernilai RM 5, akan diberikan kepada respondent di setiap hujung temuramah apabila temuramah tamat.

### **Kerahsiaan kajian**

Semua maklumat yang diperolehi akan dirahsiakan dan tidak akan didedahkan. Rakaman kajian akan dimusnah setahun selepas kajian ini dijalankan. Manakala, rekod-rekod kajian ini akan disimpan di tempat yang selamat di university Edinburgh. Data temuramah akan disimpan di komputer yang berkunci kata laluan. Sekiranya kajian ini diterbitkan, maklumat peribadi anda seperti nama dan alamat akan dikeluarkan supaya identiti anda tidak diketahui umum.

### **Penyertaan dalam kajian**

Penyertaan anda di dalam kajian ini adalah secara sukarela. Anda berhak menolak tawaran penyertaan ini atau menarik diri daripada kajian ini pada bila-bila masa tanpa sebarang penalty atau gangguan dalam perkhidmatan kesihatan yang anda patut

perolehi. Anda akan diberi borang maklumat kajian ini dan borang persetujuan sekiranya anda mengambil keputusan untuk terlibat dalam kajian ini.

Jika anda ingin keluar daripada kajian ini sebelum ia selesai, maklumat yang setakat diperolehi akan dimusnahkan dengan pengetahuan responden.

### **Hak anda, maklumat lanjut dan aduan**

Sekiranya anda mempunyai sebarang aduan berkaitan kajian ini dan penyelidik, anda boleh menghubungi penyelia saya (Professor Charlotte Clarke dan Dr Sarah Ryanas). Maklumat mereka adalah seperti tertera di hujung borang maklumat ini.

### **Semakan kajian**

Kajian ini telah disemak oleh :

1. Jawatankuasa Etika Penyelidikan Pusat, Pengajian Kesihatan Sains Sosial, Universiti Edinburgh.
2. Institut Kesihatan Negara di bawah Kementerian Kesihatan Malaysia
3. Insntitut Kajian Perubahan Tingkahlaku (IPTKA)

### **Hubungi kami untuk maklumat lanjut**

- 1) Puan Vanitha Subramaniam  
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Alamat :  
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4) Ms Hajah Faizah bte Jurimi  
Ketua Jabatan Promosi Kesihatan  
Jabatan Kesihatan Negeri Johor  
Tingkat 3 and 4, Blok B, Wisma Persekutuan  
Jalan Air Molek, 80590 Johor Bahru  
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5) Ms. Siti Sa'adiyah Hassan Nuddin,  
Pengarah  
Institut Kajian Perubahan Tingkahlaku  
Tel : 03-20821400

Sila simpan borang maklumat ini dan borang persetujuan yang telah ditandatangani.  
Terima kasih.

## Appendix 13: Consent Form (Malay language)

### Consent Form

*This form is bilingual, please obtain a Malay version if required.  
Maklumat kajian ini adalah dwi Bahasa, sila dapatkan versi Bahasa Melayu jika perlu.*

#### Study title:

The perspective of successful ageing among middle-aged Malaysian adults: A grounded theory approach

Please tick the appropriate box

1. I confirm that I have read and understood the information sheet dated \_\_\_\_\_ for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I understand that sections of my medical information may be looked at by the researcher where it is relevant to my taking part in the research.
4. I understand that information relating to me will be tape-recorded during the interview. It will be destroyed one year after the completion of the project.
5. I understand that information relating to me will not identify me by my name, and that the information obtained will be kept in locked storage. It will be destroyed one year after completion of the project.
6. I agree to use the services of an interpreter if necessary.
7. I would prefer to use a family member for the interpretation.
8. My choice of interpreter would be male/female  Male

Female

9. I agree to take part in the above study.

This paper informs you of what will happen during the study if you choose to take part. Your signature indicates that this study has been discussed with you, that your questions about the study have been answered, and also that you consent to taking part in the study. This informed consent document is not a contract. As such, you are not giving up any legal rights by signing this document. You will be given a signed copy of this paper for your own records.

Participant's signature: ..... Date of signature: \_\_\_/\_\_\_/\_\_\_

Participant's name	..... -----
Phone no	House: ----- Mobile: -----
When do you prefer to be called?	Morning <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/> OR specify the time at ___ o'clock
Home address	..... ----- ----- Postcode: -----
Email address	-----

Investigator's signature ..... Date of signature : \_\_\_/\_\_\_/\_\_\_  
**Investigator details**

Name: Vanitha Subramaniam  
Phone: 017-7951975  
Email: neethasd@gmail.com

## Appendix 14: Consent Form (Malay language)

### Borang Perseujuan

*This form is bilingual, please obtain a English version if necessary*  
*Maklumat kajian ini adalah dwi Bahasa, sila dapatkan versi Bahasa Melayu jika*

#### Tajuk Kajian:

Perspektif 'berusia secara sihat' menggunakan pendekatan 'grounded theory' di kalangan orang dewasa pertengahan usia di Malaysia

Sila tandakan  
kotak yang  
berkaitan

1. Saya mengesahkan bahawa saya telah membaca dan memahami kandungan borang maklumat berkaitan kajian ini seperti bertajuk di atas yang bertarikh \_\_\_\_\_ dan juga saya telah diberi peluang untuk bertanya soalan berkaitan kajian ini.
2. Saya faham bahawa penglibatan saya adalah secara sukarela, dan boleh menarik diri pada bila-bila masa tanpa memberikan sebarang alasan.
3. Saya faham bahawa maklumat rawatan saya mungkin dilihat oleh penyelidik, di mana ia berkaitan dengan kajian.
4. Saya faham bahawa maklumat berkaitan saya direkod semasa sesi temuramah. Pita rakaman ini akan dimusnahkan setahun selepas projek kajian ini tamat.
5. Saya faham bahawa maklumat saya tidak akan dinyatakan bersama nama saya, maklumat tersebut akan disimpan di peti berkunci. Ia akan dimusnahkan setahun selepas projek kajian ini tamat.
6. Saya setuju untuk menggunakan khidmat penterjemah jika perlu.
7. Saya lebih suka menggunakan ahli keluarga bagi penterjemahan
8. Pilihan jurubahasa saya adalah  Lelaki  
 Perempuan

9 Saya bersetuju untuk mengambil bahagian dalam kajian ini

Borang persetujuan kajian ini menerangkan tentang keadaan yang diharap berlaku apabila anda menyertai kajian ini. Dengan menandatangani dokumen ini, Tuan/Puan mengesahkan bahawa perkara ini telah dibincangkan dan anda akan terlibat di dalam kajian ini. Dokumen ini adalah bukan perjanjian, maka anda tidak terikat dengan mana-mana isu perundangan. Dengan menandatangani borang persetujuan ini, anda membenarkan penganalisaan dan penggunaan data hasil dari kajian ini. Satu salinan dokumen ini akan diberi untuk simpanan tuan/puan.

Tandatangan responden: ..... Tarikh tandatangan \_\_\_/\_\_\_/\_\_\_\_\_

Nama responden	----- -----
No telepon	Rumah: -----  Bimbit: -----
Masa tuan/puan selesa untuk dihubungi	<input type="checkbox"/> Pagi <input type="checkbox"/> Tengahari <input type="checkbox"/> Petang  ATAU sila tuliskan masa yang sesuai iaitu pada pukul _____ am/pm
Alamat rumah	----- -----  Poskod: -----
Alamat email	----- -----

Tandatangan penyelidik ..... Tarikh tandatangan: \_\_\_/\_\_\_/\_\_\_\_\_

Maklumat penyelidik

**Nama:** Vanitha Subramaniam

**No telefon :** 017-7951975

**Alamat email :** [neethasd@gmail.com](mailto:neethasd@gmail.com)

## Appendix 15 – Personal Data Recruitment Form

### Personal data recruitment form

*This form is bilingual, please obtain a Malay version if required.  
Borang ini dalam dwi Bahasa, sila dapatkan versi Bahasa Melayu jika perlu.*

#### Study title:

The perspective of successful ageing among middle-aged Malaysian adults: A grounded theory approach

**CIRCLE THE LETTER next to the answer below or fill in the blanks with answers (whichever applicable) that most accurately tell us about you. Circle only one answer for each question. If you are unsure of any questions, please get some assistance.**

#### Personal Details

- 1) Name : -----
- 2) Gender: a. Male                      b. Female
- 3) Age in years:   years old
- 4) Race: a. Malay   b. Chinese   c. Indian  
D. Others, specify -----
- 5) Education level:  
A. Not educated                      b. Primary education                      c.  
Secondary education                      d. Higher education
- 6) Marital status: a. Never married                      b. Married/partnered  
c. Divorced/separated                      d. Widowed
- 7) Occupation: -----
- 8) Household income per year: RM -----
- 9) Do you have any children?  
A. Yes, please specify the number of children -----                      b. No
- 10) Ages of children?
  - i. 1<sup>st</sup> child \_\_\_\_\_
  - ii. 2<sup>nd</sup> child \_\_\_\_\_
  - iii. 3<sup>rd</sup> child \_\_\_\_\_
  - iv. 4<sup>th</sup> child \_\_\_\_\_
  - v. 5<sup>th</sup> child \_\_\_\_\_
  - vi. 6<sup>th</sup> child \_\_\_\_\_

11) Are you residing with an elder (parents, grandparents, in law, etc.)?  
 A. Yes                      b. No

12) Are you currently taking care of an elder?  
 A. Yes                      b. No

13) Chronic health conditions: Please circle all of the chronic health conditions listed below that you have been told by a doctor that you have.

- a. Hypertension / high blood pressure
- b. Arthritis
- c. Heart disease
- d. Diabetes
- e. Lasting effects of a stroke
- f. Respiratory disease such as chronic bronchitis / asthma / emphysema
- g. Cancer
- h. Other chronic disease, please specify -----

14) How would you describe your health?  
 A. Very good              b. Good              c. Fair              d. Poor

<b>Tell us more about yourself</b>			
(answer by <b>ticking</b> <input checked="" type="checkbox"/> the box or <b>filling</b> in with an appropriate answer about yourself)			
<b>Functional ability:</b>			
14)	Able to live independently, without help from another person 'more than occasionally'	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15)	Need assisted living services such as help with bathing, medication or getting around	Yes <input type="checkbox"/>	Partially independent (not needing services, but have help from family members at times) <input type="checkbox"/>
			No <input type="checkbox"/>
<b>Lifestyle:</b>			
16)	Do you smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Ex-smoker <input type="checkbox"/>
17)	Do you drink alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Ex-drinker <input type="checkbox"/>





- ii. Anak kedua \_\_\_\_\_
- iii. Anak ketiga \_\_\_\_\_
- vi. Anak kelima \_\_\_\_\_
- vii. Anak keenam \_\_\_\_\_

11) Adakah anda tinggal bersama warga emas (Ibubapa, datuk, nenek, ibu/bapa mertua, lain-lain)?  
 A. Ya                      b. Tidak

12) Pada masa sekarang adakah anda menjaga orang tua?  
 A. Ya                      b. Tidak

13) Penyakit kronik: Sila bulatkan semua penyakit kronik yang diberitahu oleh doctor bahawa anda sedang menghidapi.

- i. Tekanan darah tinggi
- j. Sakit sendi (Arthritis)
- k. Penyakit jantung
- l. Kencing manis
- m. Angina ahmar
- n. Masalah respiratori seperti asma/ masalah pernafasan/ emphysema
- o. Kanser
- p. Penyakit kronik lain, sila nyatakan -----

14) Bagaimana anda menggambarkan keadaan kesihatan anda?  
 A. Sangat bagus    b. Bagus            c. Sederhana        d. Teruk

<b>Beritahu kami lebih lanjut mengenai anda</b>			
(Tandakan <input checked="" type="checkbox"/> di ruang or tuliskan jawapan yang paling menggambarkan diri anda			
<b>Functional ability:</b>			
14)	Dapat hidup secara bebas, tanpa bantuan daripada orang lain (atau hanya beberapa kali dapat bantuan dengan orang lain)	Ya <input type="checkbox"/>	Tidak <input type="checkbox"/>
15)	Memerlukan bantuan menjalani kehidupan harian, contohnya semasa mandi, makan ubat atau berjalan keluar	Ya <input type="checkbox"/>	Tidak <input type="checkbox"/>
<b>Gaya Hidup:</b>			
16)	Adakah anda merokok?	Ya <input type="checkbox"/>	Tidak <input type="checkbox"/> Pernah Merokok <input type="checkbox"/>
17)	Adakah anda minum alkohol?	Ya <input type="checkbox"/>	Tidak <input type="checkbox"/> Pernah Minum <input type="checkbox"/>
18)	Pada skala 1-10, bagaimana anda menilai tahap stres anda (1 = sangat rendah 10 = sangat tinggi) ?	<div style="display: flex; justify-content: space-between;"> <span>1 <input type="checkbox"/></span> <span>2 <input type="checkbox"/></span> <span>3 <input type="checkbox"/></span> <span>4 <input type="checkbox"/></span> <span>5 <input type="checkbox"/></span> <span>6 <input type="checkbox"/></span> <span>7 <input type="checkbox"/></span> <span>8 <input type="checkbox"/></span> <span>9 <input type="checkbox"/></span> <span>10 <input type="checkbox"/></span> </div> <div style="text-align: center; margin-top: 5px;"> </div>	
19)	Berapa kerapkah anda mengambil bahagian dalam aktiviti fizikal dalam seminggu?	<input type="checkbox"/> <input type="checkbox"/> Kali dalam seminggu	

20)	Adakah anda berfikir anda makan diet pemakanan yang sihat?	Ya <input type="checkbox"/>	Tidak <input type="checkbox"/>
-----	--	-----------------------------	--------------------------------

21) Terima kasih kerana sudi menjawab soalan-soalan ini. Sila tuliskan komen tambahan yang boleh membantu kita memahami pandangan anda.

-----

-----

## **Appendix 17- Prompt Sheet used for interview**

### **Study title:**

**The perspective of successful ageing among middle-age Malaysian adults: A grounded theory approach**

#### **1) Introduction**

- i) Can you please tell me about the things that you enjoy most or are proud of?

#### **2) Understanding of ageing and context of ageing successfully**

- i) How would you like to see yourself in five to ten years' time?
- ii) How do you intend to age successfully?

#### **3) Understanding of subjective norms that motivate action toward SA**

- i) What are the aspects that motivate or become a barrier for you towards ageing successfully?

#### **4) Perceived behaviour control that challenge intention for SA**

- 1) How do you see yourself associated with the risks of ageing?

#### **2) Closure**

- a. Is there anything else in addition to what you have discussed that you think that I should know?

## Appendix 18 –Renewal approval from the Medical Research and Ethics Committee



**JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN**  
*(Medical Research & Ethics Committee)*  
KEMENTERIAN KESIHATAN MALAYSIA  
d/a Institut Pengurusan Kesihatan  
Jalan Rumah Sakit, Bangsar  
59000 KUALA LUMPUR



Tel : 03-2287 4032/2282 043 / 2282 9085  
03-2282 9082/2282 1402/2282 1448  
Faks: 03-2282 0015

Ref : (9) KKM/NIHSEC/P15-217  
Date: 24 MAC 2016

**VANITHA A/P SUBRAMANIAM**  
**HOSPITAL SULTAN ISMAIL**

Annual Ethical Renewal for 2016

NMRR-14-1409-22872 (IIR)

**THE PERSPECTIVE OF SUCCESSFUL AGEING AMONG MALAYSIAN MIDDLE AGED ADULTS: A STUDY OF GROUNDED THEORY**

With reference to the 'Continuing Review Form' submitted **18 February 2016**, we are pleased to inform that the conduct of the above study has been granted approval for a year by the Medical Research & Ethics Committee, Ministry of Health Malaysia. Please note that the approval is valid until **23 MAC 2017**. To renew the approval, a completed 'Continuing Review Form' has to be submitted to MREC at least 2 months before the expiry of the approval.

The MREC, Ministry of Health Malaysia operates in accordance to the International Harmonization Good Clinical Practice Guidelines.

Thank you.

"BERKHIDMAT UNTUK NEGARA"

Yours sincerely,

.....  
**(DATO' DR CHANG KIAN MENG)**  
Chairman  
Medical Research & Ethics Committee  
Ministry of Health Malaysia

## **Appendix 19 – Instructions for interview activities at theoretical sampling**

### **Activity 1: Understanding of ageing**

You will be given three activities. Each activity will last for around 20 minutes, except for the final activity which has an estimated duration of 30 minutes. Separate questions may be asked following completion of these activities, where applicable. However, you are permitted to withdraw from the interview at any point in time, without any restriction.

#### **Instructions for activity**

In this first activity, there are some cards arranged in front of you that state the crux of the discussions about the idea of ‘becoming old’ that were shared by some of the participants during the previous data collection. With this understanding as a basis, you are asked to identify or order those primary events that closely resemble your own understanding of the context of ageing and attaining an old age.

You are free to bring out other scenarios that are not mentioned on these cards but that you consider to be important and closely relevant to your perception of attaining ‘old’ age.

<b>I am old-aged when my children get settled and start a career of their own.</b>
<b>I am ageing when I become a grandparent.</b>
<b>I am ageing when I am not as healthy as before or visible changes are noticed.</b>
<b>I am ageing when I am financially secure.</b>

**I will consider myself old when I behave like a child again.**

**I will consider myself to be getting old when I become wiser.**

**I will consider myself to be getting old when I become more spiritually connected.**

**I will consider myself old when I don't need to be productively active and have more leisure time.**

## **Activity 2: Perceived behavioural factors for achieving 'ageing well'.**

### **Talking points for the researcher:**

In this second activity, you are required to categorise each of the below perceived factors of 'ageing well' against the timescales such as short-term, medium-term and long-term against which they would fit according to your priorities in a non-linear order. I would like to know what is most important to you right now that you are focusing on in your life at the moment, and also any issues that you are considering retaining for a later time.

You may place each factor in one or more category of timescales or mediate in between two or more timescales, and we shall discuss the responses further.

<b>Connecting relationships</b>
<b>Conceiving mental strength</b>
<b>Approaching spiritual needs</b>
<b>Engaging in community work</b>
<b>Gaining social normality as to how the older people in the community at large approach their later life</b>
<b>Accepting your status in life as being directed by God/fate/karma</b>
<b>Minimising disruptive events such as health issues, family relationship, etc.</b>
<b>Sustaining independence and freedom to make own choices/decisions/opinions</b>
<b>Obtaining an encouraging environment such as having a supportive environment, retirement plans or healthcare policies</b>

<b>Ensuring financial security</b>
<b>Changing lifestyle</b>

### **Activity 3: Conceptual framework**

#### **Talking points for the researcher:**

In the earlier stages of my research, some people talked about the below concepts and I would like to know ‘what does that mean to you?’ There are four things that appeared to be very important in how people approach getting older: uncertainty, consciousness of past events, the current moment and vision of their later life demands, and the benchmarking they develop for the future.

I will read aloud vignettes from some of the participants in the previous interviews and wish to discuss what they mean to you. Later, you will be given a few cards and will be asked to discuss the relationships between them from your own point of view.

#### **Vignette 1 (for the healthy participants)**

*‘I can do my daily chores without the help of others now, but in the future my body might let me down. I am single now, so if I get sick, there would be no one to take care of me. This leads to an uncertainty for the future; in the present days, therefore, I am engaging in activities that may give some assurance to my later life.’*

#### **Vignette 2 (for the participants with chronic illnesses)**

*‘I can do my daily chores without the help of others now, but in the future my body might let me down. I am suffering from three chronic diseases, including a heart issue, which might be controlled, but they cannot be cured. Even though I have undergone bypass, my heart may collapse at some point. This leads to uncertainty for the future;’*

*in present days, therefore, I am engaging in activities that may give some assurance to my later life I could see the difference after I was fell sick. Thinking that now I have come to my awareness. My diet needs to be healthier. Maybe engage in spiritual activities more than before at old age. Our death is unpredictable. But, if blessed with a long life, normally that's what people do when they become older. I also want to improve my relationships with the people who are important to me.'*

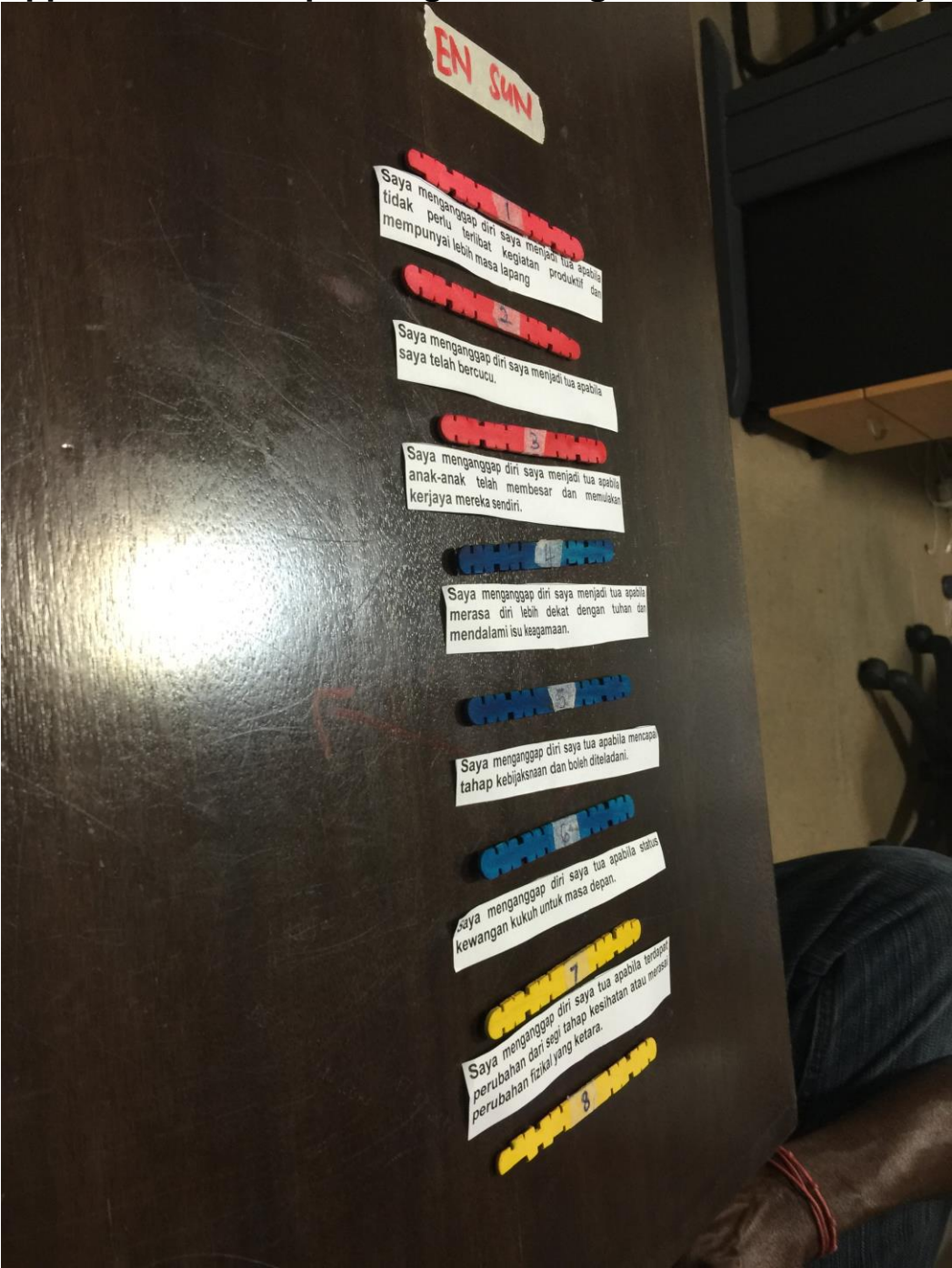
After listening to the vignette, participants discussed the questions below:

1. What is your perception of the vignette above?
2. How do you connect the events of 'uncertainty' and 'certainty' in your present life to help shape your expectation on future ageing experiences?
3. How do you cope with uncertain incidents in your life to create assurance or certainty for your later life?

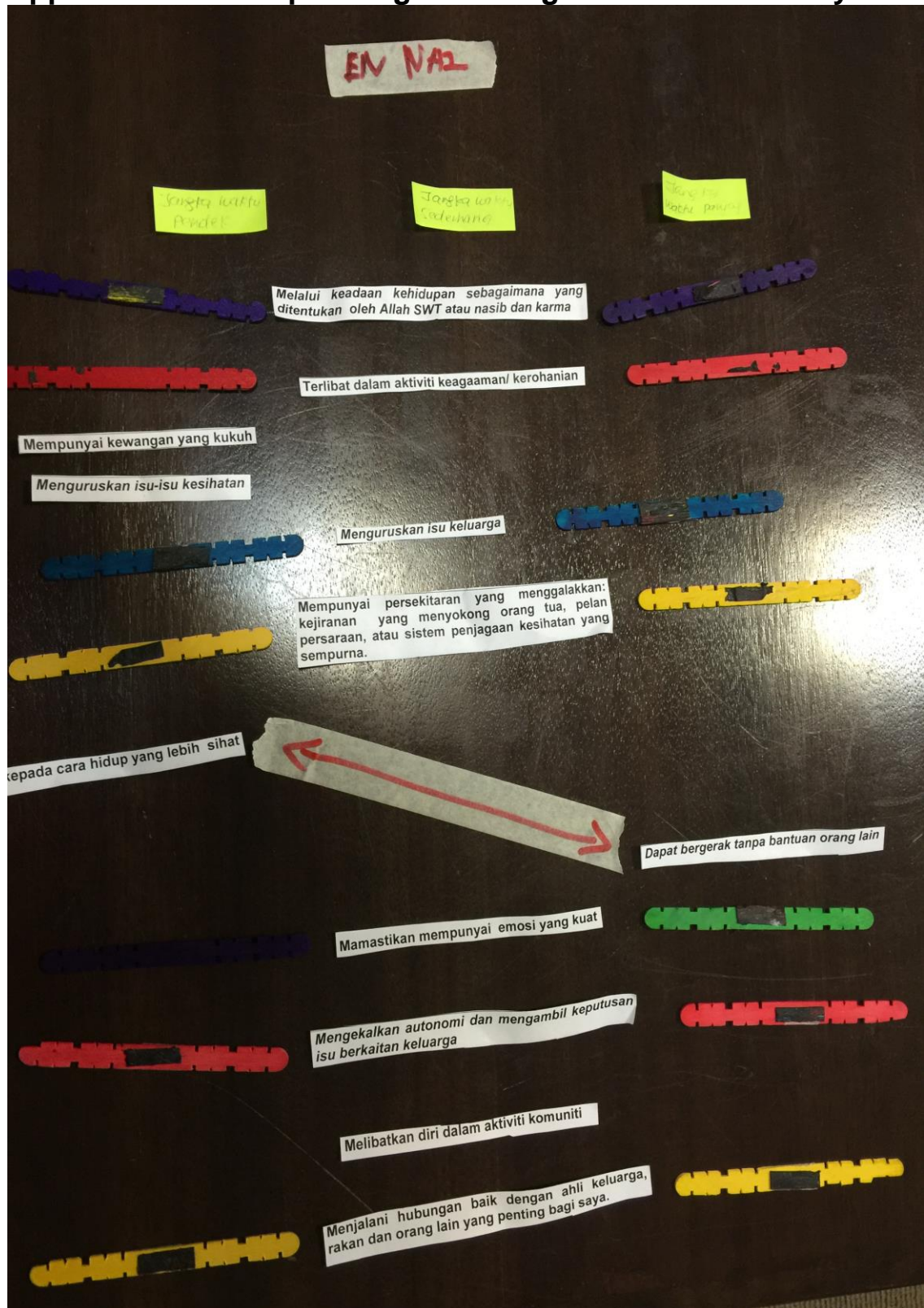
## Appendix 20- Image of interview room



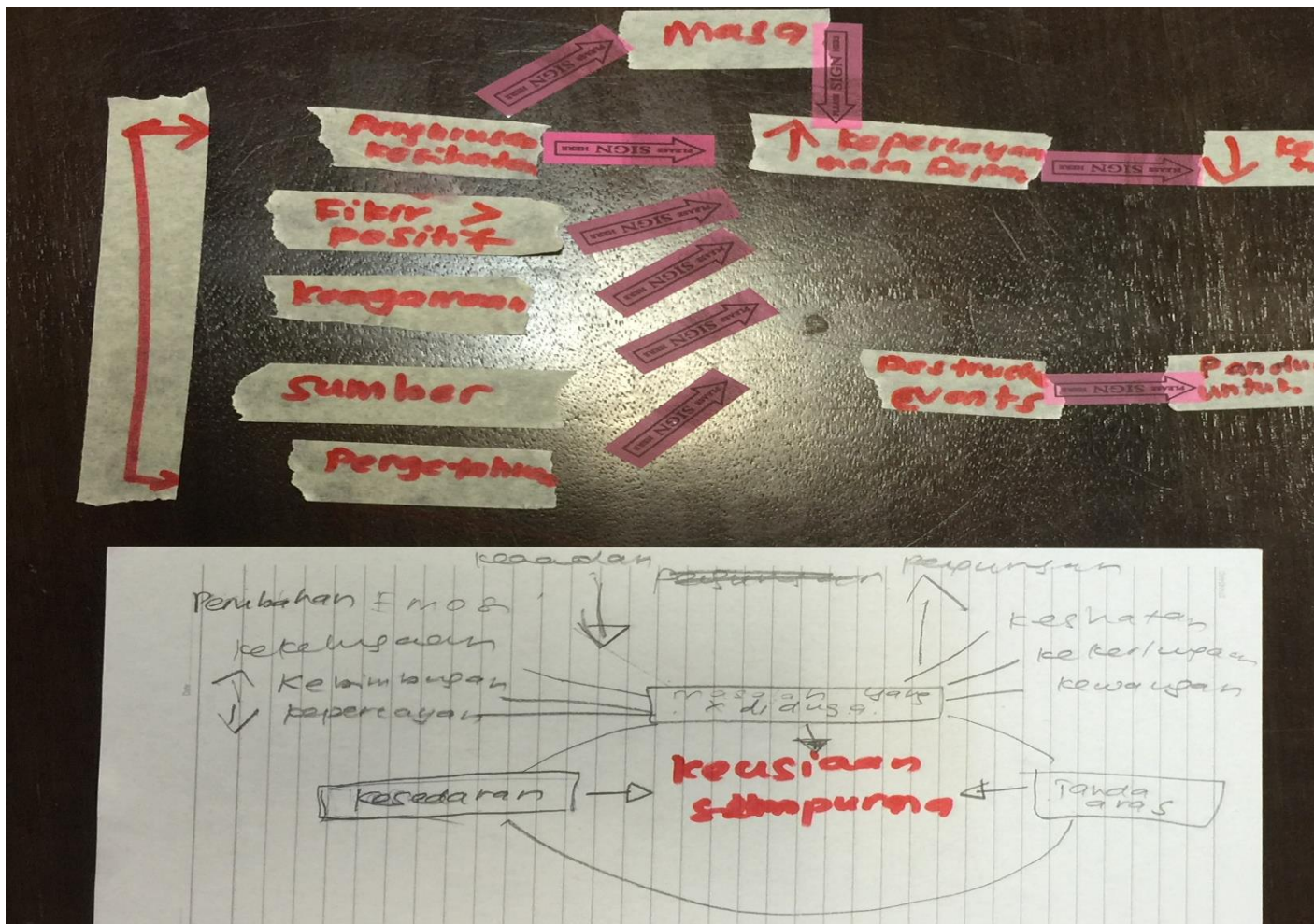
Appendix 21-Example image showing outcome of Activity 1



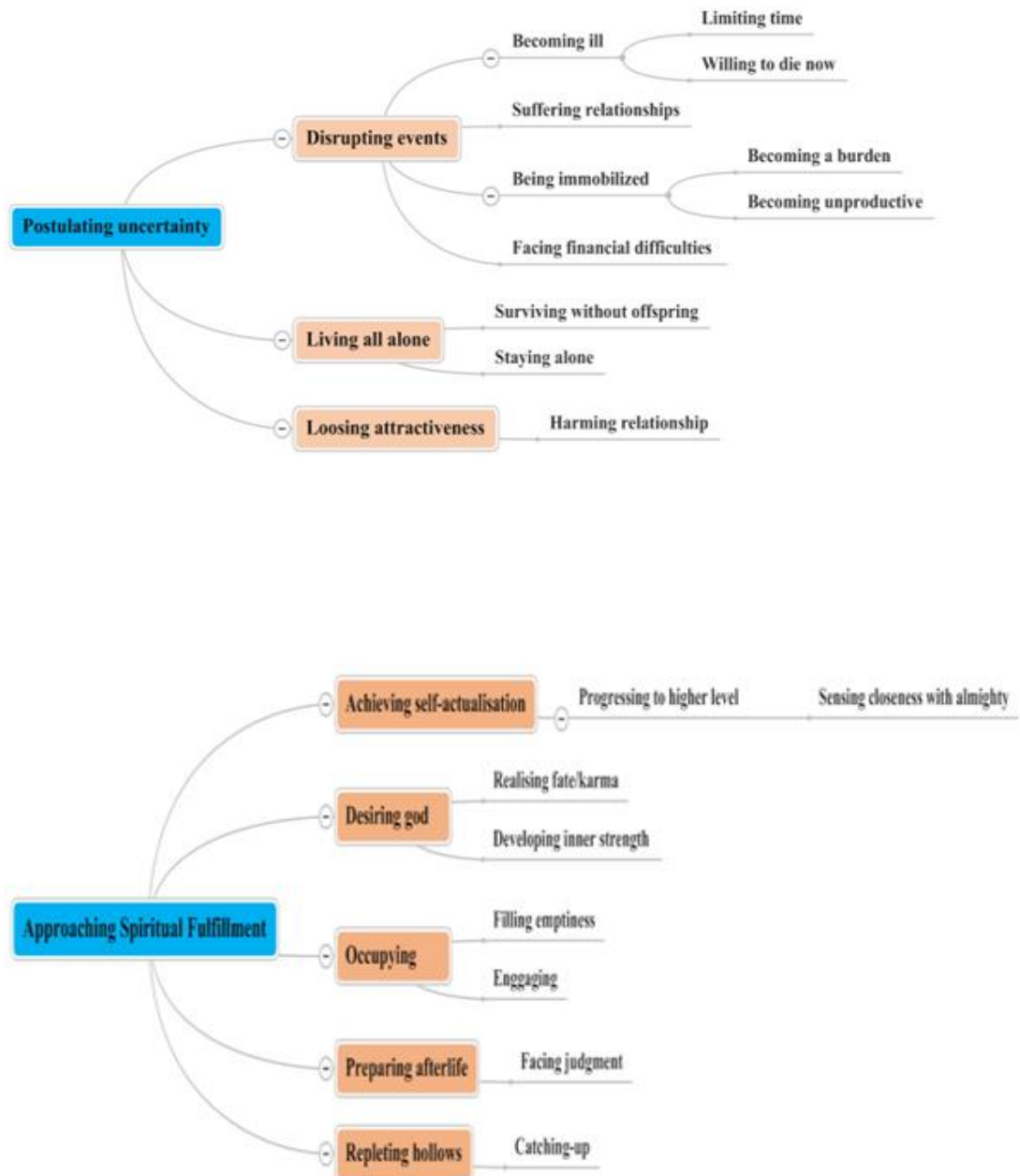
## Appendix 22- Example image showing outcome of Activity 2



Appendix 23- Example image showing outcome and discussion of Activity 3



## Appendix 24: Example of initial coding



## **Appendix 25 – Example of Memo**

Date: 19 April 2016

The category of ‘deteriorating health’ came from the uniformities that I noticed from various integrated incidents. It seems that ‘deteriorating health’ is the main factor in bringing forth uncertainty with regard to later life: uncertainty about ‘how long my life would be?’ and ‘what is it going to be like?’ Many participants, even those in a good health condition, feel insecure and uncertain about their later life, with the uncertainty not limited to health events, but also arising due to family issues, such as their children faring worse or being less successful in life or the fact that they may have financial burdens. So, the disruption of anticipated events or an anticipated future somewhat underpin the behaviours for successful ageing. I noticed that more core categories emerged from the consolidation of the various similarities and the dissimilarities that fit in a sequence and to different incidents. Would the perspective of health be different among healthy participants, between male and female, those who have better support from family members or people with a terminal illness such as renal failure or a chronic illness such as diabetes?

Also, another thing I noticed was preparation and attempts to repair the damage of the past. I was aware of repetitive and persistent notation from many of the research participants who said, ‘I’m going to the mosque now more than I used to’. This can be interpreted as preparation for the future as a way of trying to enhance certainty as to them by doing all these activities one day they can create more certainty to their future. So this was seen in statements such as, ‘I’m going to the mosque more frequently’, and ‘when I was younger, I can’t, but now I go every day’. Since it seemed as if they were trying to catch up some aspect, I made a note that middle age is a time for people to repair the damage to their life and future and also the past. In addition, it can be a time for attempting to build a network centred around the family as part of the process of getting prepared to manage uncertainty in the future, especially in the event that there is no carer present. This included those people who are single, who were making efforts to create a network with their extended family, friends or to be flexible with everyone around them in order that they could have more security, especially with

regard to any future ailments. This kind of protection and safety insurance was an attempt to build up something that would protect their well-being later. It is quite an interesting thing that goes across the generations.

The first participant, a single woman, mentioned that it was really important to have a family and to have a partner because this is also part of the insurance. This emerged consistently throughout the data. It was an interesting dynamic whereby people were reflecting back on whether they had done enough for their future, to create certainty. So, summarising from the interviews, there was a prevalent perception that: I have no idea how long my life is going to be, what it is going to be like, but let me have a bit more certainty about the people around for me.

But how do people visualise and recognise this uncertainty? Are the people in this study guiding themselves through different situations in their present life based on their past experiences and using these as a benchmark for steering their future. So, when there is some form of disruption in relation to anticipated events or a future that contains a health issue, the absence of a carer and financial instability, there needs to be some alteration to an element of SA that had been set earlier. However, this seemed to create conflict within them, resulting in emotional turbulence. Thus, the data suggested that there may be a temporal consciousness that is felt by crossing the past and present circumstances with future aspirations.

## **Appendix 26 – Researcher Journal**

**Date 11/05/2015**

I remembered that I was attempting to apply for ethical approval level one with the assumption that interviewing the mature adults about their future should be less demanding in terms of emotional trauma and with no significant risk anticipated. However, I was asked to change the ethical application to level 2 by my supervisors owing to the fact that there was the potential for unforeseen risk such as embarrassment arising among the participants from answering personal questions or the possibility of some of the participants becoming upset when remembering things from their past life or thinking about getting older. Hence, I was prepared to some extent for how to respond to these situations, although from my point of view they would occur only in rare circumstances. However, during my first interview, I felt challenged. The first participant, a male respondent, who happened to be a previous client of mine from the smoking cessation clinic, broke down in tears.

Today, I have witnessed an even harder interview, when another participant, also an ex-client from the smoking cessation clinic, asked me for personal advice as to whether or not to go for heart surgery. He wanted me to be part of his decision-making. Also, he revealed a secret and asked my opinion regarding the consequences of it that he is currently facing. I felt strange acting in the role of interviewer; I could sense he knew my viewpoint to a certain level. I could not offend him, but at the same time I cannot escape from giving a response. Being a health professional, I knew that I needed to persuade him to go for the surgery, but it was complicated as I am also a researcher who should not contaminate the data as the interview was still ongoing. I am stuck in an ethical dilemma; should I reveal his decision to his doctor and get him a counselling session or should I protect the confidentiality of the data gathered?

## Appendix 27- Participants' medical and behaviour modification progress notes (Malay language)

### 1. En kassim (365685) 012-7062461

- **Berat** – 83.2kg
- **Tinggi** – 153cm
- **Diagnose:**
- *Acute Anteroseptal STEMI Killip Class II*
- **Kekerapan kemasukkan ke wad:**
- *Ikali sahaja*
- **Status pengurusan penyakit oleh pesakit:**
- *Mengambil ubatan dengan dos pada masa yang ditetapkan*
- *Mengawal cara pemakanan*
- *Berhenti merokok*
- **Perubahan yang dicapai:**
- *Keadaan kesihatan semakin baik*
- *Kurang mengalami sakit jantung yang teruk*
- *Rasa semakin gembira dengan kehidupan sekarang*
- **Berapa lama sakit:**
- *Tahun 2012*

### 2. En Suntheran A/L Monisamy (382648) 014-6115913

- **Berat** – 78kg
- **Tinggi** – 162cm
- **Diagnose:** *Unstable angina, Peptic Ulcer Disease*
- **Kekerapan kemasukkan ke wad**
- *Ikali sahaja*
- **Status pengurusan penyakit oleh pesakit**
- *Mengambil ubatan dengan dos dan pada masa yang telah ditetapkan.*
- *Mengawal pemakanan. Tidak mengambil makanan berminyak, pedas dan makanan berlemak.*
- *Tidak mengambil minuman berkafein dan alcohol*
- *Berhenti merokok*
- **Perubahan yang dicapai**
- *Sakit yang dialami (gastritis) berkurangan*
- *Tidak mendapat serangan sakit jantung semula*
- *Gembira dengan kehidupan sekarang*
- **Berapa lama sakit**
- *Unstable Angina – mulai tahun 2012*
- *Gastritis – mulai tahun 2012*

### 3. En Nazri (400939) 012-7653210

- **Berat** – 61kg
- **Tinggi** – 165cm

- **Diagnose:**
- 1. *Acute inferolateral MI with posterior involvement, successful thrombolysis-Killip I*
- 2. *Chronic smoker with hypercholesterolemia*
- **Kekerapan kemasukkan ke wad**
- *1 kali sahaja*
- **Status pengurusan penyakit oleh pesakit**
- *Mengambil ubata dengan dos dan masa yang telah ditetapkan*
- *Mengawal pengambilan makanan. Tidak megambil makanan berminyak dan berlemak.*
- *Tidak mengambil terlalu kerap minuman berkafein.*
- *Berhenti merokok*
- **Perubahan yang dicapai**
- *Kurang mendapat serangan sakit jantung yang teruk semula*
- *Paras kolestrol berkurangan dalam darah melalui ujian darah*
- *Hidup dengan lebih selesa*
- **Berapa lama sakit**
- *Mulai tahun 2012*

#### 4. En Aspar (356509) 017-7366796

- **Berat** – 87kg
- **Tinggi** – 162cm
- **Diagnose:**
- 1) *Unstable angina*
- 2) *Underlying IHD with Triple disease, DM, HPT, Ex-smoker*
- **Kekerapan kemasukkan ke wad**
- *3 kali*
- *(4.5.2012-6.5.2012), (25.6.2013-28.6.2012), (4.4.2016-6.4.2016)*
- **Status pengurusan penyakit oleh pesakit**
- *Mengambil ubatan dengan dos dan masa yang telah ditetapkan.*
- *Mengahdiri TCA mengikut tarikh dan waktu yang telah diberi*
- *Mengamalkan gaya hidup yang sihat*
- *Mengawal pengambilan makanan dan minuman. Tidak mengambil makanan yang berlemak, berminyak.*
- **Perubahan yang dicapai**
- *Kurang mendapat serangan sakit jantung yang teruk*
- *Dapat hidup dengan selesa dengan mengawal stress*
- *Dapat melakukan aktiviti ringan dirumah untuk menjaga kesihatan*
- **Berapa lama sakit**
- *Mulai tahun 2012*

#### 5. Pn Vallerie (397992) 016-7483383

- **Berat** – 90.5kg

- **Tinggi** – 165cm
- **Diagnose:**
- 1) *Hx of Acute inferior STEMI with right ventricular involvement, Killip 4*
- 2) *Hypercholesterolemia*
- **Kekerapan kemasukkan ke wad**
- *1 kali (11.12.2012-14.12.2012)*
- **Status pengurusan penyakit oleh pesakit**
- *Mengambil ubatan dengan dos dan masa yang telah ditetapkan.*
- *Menghadiri TCA mengikut tarikh dan waktu yang telah diberi*
- *Mengamalkan gaya hidup yang sihat*
- *Mengawal pengambilan makanan dan minuman. Tidak mengambil makanan yang berlemak, berminyak.*
- **Perubahan yang dicapai**
- *Kurang mendapat serangan sakit jantung yang teruk*
- *Dapat hidup dengan selesa dengan mengawal stress*
- *Dapat melakukan aktiviti ringan dirumah untuk menjaga kesihatan*
- **Berapa lama sakit**
- *Mulai tahun 2012*

#### 6. Pn Daliah (10932)

- **Berat** – 73kg
- **Tinggi** – 150cm
- **Diagnose:**
- 1) *Hypertension*
- 2) *ESRF*
- **Kekerapan kemasukkan ke wad**
- *2 kali (11.7.2011-29.7.2011),(28.9.2016-1.10.2016)*
- **Status pengurusan penyakit oleh pesakit**
- *Datang untuk cuci darah pada hari yang telah ditetapkan*
- *Menghadiri TCA mengikut tarikh yang diberi*
- *Mengamalkan cara hidup sihat*
- *Mengawal pengambilan makanan dan airan mengikut nasihat yang telah diberi*
- **Perubahan yang dicapai**
- *Kurang mengalami kesesakkan nafas disebabkan lebanh cecair dalam badan*
- *Bacaan tekanan darah stabil*
- **Berapa lama sakit**
- *Mulai tahun 2009*
- **Berapa lama buat dialysis**
- *Mulai tahun 2009*

#### 7. Aunty Beck Gek Eng (2785)

- **Berat** – 56kg
- **Tinggi** – 148cm
- **Diagnose:**
- 1) ESRF since 2002
- 2) HPT
- 3) Renal hyperparathyroidism
- **Kekerapan kemasukkan ke wad**
- 6 kali (1.10.2012-8.10.2012),(29.3.2013-4.4.2013),(4.6.2014-12.6.2014),(30.11.2015-27.12.2015),(23.6.2016-1.7.2016),(15.7.2016-3.8.2016)
- **Status pengurusan penyakit oleh pesakit**
- *Datang untuk cuci darah pada hari yang telah ditetapkan*
- *Menghadiri TCA mengikut tarikh yang diberi*
- *Mengamalkan cara hidup sihat*
- *Mengawal pengambilan makanan dan airan mengikut nasihat yang telah diberi*
- **Perubahan yang dicapai**
- *Kurang mengalami kesesakkan nafas disebabkan leban cecair dalam badan*
- *Bacaan tekanan darah stabil*
- **Berapa lama sakit**
- *Mulai tahun 2002*
- **Berapa lama buat dialysis**
- *Mulai tahun 2002*

## 8. Pn Bijah Koyah (171438)

- **Berat** – 83.5kg
- **Tinggi** – 154cm
- **Diagnose:**
- 1) HPT for 9 years
- 2) DM for 14 years
- 3) ESRF for 7 years
- 4) Right DFU
- **Kekerapan kemasukkan ke wad**
- 5 kali (29.9.2011-5.10.2011),(25.4.2012-29.4.2012),(19.4.2013-26.4.2013),(31.7.2015-5.8.2015),(9.6.2016-17.6.2016)
- **Status pengurusan penyakit oleh pesakit**
- *Datang untuk cuci darah pada hari yang telah ditetapkan*
- *Menghadiri TCA mengikut tarikh yang diberi*
- *Mengamalkan cara hidup sihat*
- *Mengawal pengambilan makanan dan airan mengikut nasihat yang telah diberi*
- **Perubahan yang dicapai**
- *Kurang mengalami kesesakkan nafas disebabkan leban cecair dalam badan*

- *Bacaan tekanan darah stabil*
- **Berapa lama sakit**
- *Mulai tahun 2010*
- **Berapa lama buat dialysis**
- *Mulai tahun 2010*

## Appendix 28-Transcripts and translation of confidential agreement

### Transcriber and translator confidentiality Agreement

**Name of service provider:** Dr. Thavamaran Kanesan  
**Company name :** Proofreading By a UK PhD  
**Business registration:** NS0163502-K

**Title of research study:** The perception model of successful ageing among middle aged Malaysian: A grounded theory approach


**Researcher :** Vanitha Subramaniam

An important part of conducting research is having the research policy and confidentiality. In signing below, you are agreeing to respect the participant's right to privacy and that of the people and organizations that may be included in the information collected. You are asked to respect people right to confidentiality by not discussing the information collected in public, with friends or family members.

I, Dr. Thavamaran Kanesan the service provider for transcript and translate, agree to:

1. Keep all the research information shared confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts) with anyone than the researcher.
2. Pass all research information in any form or format (e.g., disks, tapes, transcripts) to the researcher when I have completed the researcher tasks.
3. Destroy all research information regarding this project that is not returnable to the Researcher (e.g., information stored on computer and hard drive)

Signature of service provider,

.....  
Name :   
Thavamaran Kanesan

Date : 20/09/16

**Transcriber and translator confidentiality Agreement**

**Name of service provider:** Rasyedah Ahmad Ragi

**Company name :** Rauhah Ingenuity, Research Services & Consultation

**Business registration:** JM0742184-V

**Title of research study:**

**Researcher :** Vanitha Subramaniam

An important part of conducting research is having the research policy and confidentiality. In signing below, you are agreeing to respect the participant's right to privacy and that of the people and organizations that may be included in the information collected. You are asked to respect people right to confidentiality by not discussing the information collected in public, with friends or family members.

I, Rasyedah Ahmad Ragi the service provider for transcript and translate, agree to:

1. Keep all the research information shared with me confidentially by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts) with anyone than the researcher.
2. Keep all research information in any form or format (e.g., disks, tapes, transcripts) to the Researcher when I have completed the researcher tasks.
3. Destroy all research information regarding this project that is not returnable to the Researcher (e.g., information stored on computer and hard drive)

Signature of service provider,



.....  
Name : Rasyedah Ahmad Raqi

Date : 25/7/2016

## Appendix 29-Example of alert created for new literature

New search results: Disruptive life events in middle age



is.helpline@ed.ac.uk  
Wed 03/01, 00:08  
SUBRAMANIAM Vanitha

Reply all

There are new items in your saved search2

All new records can be found via the following link:

[http://discovered.ed.ac.uk/primo\\_library/libweb/action/search.do?vl\(91575025UI2\)=any&vl\(91572502UI1\)=any&vl\(8819886UI2\)=AND&amp=&fn=search&indx=1&vl\(8819895UI6\)=Year&vl\(8819888UI1\)=AND&vl\(26960687UI4\)=all\\_items&dscnt=1&vl\(1UIStartWith0\)=contains&vl\(8819886UI0\)=AND&vl\(1UIStartWith2\)=contains&vid=44UOE\\_VU1&vl\(8819893UI6\)=00&mode=Advanced&tab=default\\_tab&vl\(91591844UI3\)=any&vl\(freeText3\)=&vl\(freeText1\)=&vl\(8819896UI6\)=00&fromLogin=true&dsmtp=1484066142568&frbg=&vl\(8819886UI3\)=AND&pcAvailabilityMode=true&vl\(8819897UI6\)=00&vl\(1UIStartWith3\)=contains&vl\(91557435UI0\)=any&vl\(1UIStartWith1\)=contains&vl\(8819898UI6\)=Year&ct=facet&srt=rank&Submit=Search&institute=&vl\(128730122UI5\)=eng&vl\(freeText2\)=&dum=true&vl\(freeText0\)=disruptive%20life%20events%20in%20middle%20age&vl\(8819894UI6\)=00&savedSearchId=1227981388&fromDate=20171227000000](http://discovered.ed.ac.uk/primo_library/libweb/action/search.do?vl(91575025UI2)=any&vl(91572502UI1)=any&vl(8819886UI2)=AND&amp=&fn=search&indx=1&vl(8819895UI6)=Year&vl(8819888UI1)=AND&vl(26960687UI4)=all_items&dscnt=1&vl(1UIStartWith0)=contains&vl(8819886UI0)=AND&vl(1UIStartWith2)=contains&vid=44UOE_VU1&vl(8819893UI6)=00&mode=Advanced&tab=default_tab&vl(91591844UI3)=any&vl(freeText3)=&vl(freeText1)=&vl(8819896UI6)=00&fromLogin=true&dsmtp=1484066142568&frbg=&vl(8819886UI3)=AND&pcAvailabilityMode=true&vl(8819897UI6)=00&vl(1UIStartWith3)=contains&vl(91557435UI0)=any&vl(1UIStartWith1)=contains&vl(8819898UI6)=Year&ct=facet&srt=rank&Submit=Search&institute=&vl(128730122UI5)=eng&vl(freeText2)=&dum=true&vl(freeText0)=disruptive%20life%20events%20in%20middle%20age&vl(8819894UI6)=00&savedSearchId=1227981388&fromDate=20171227000000)

Topophilia and economic value of lifestyle travellers

[http://discovered.ed.ac.uk/primo\\_library/libweb/action/diDisplay.do?docid=TN\\_tayfranc10.1080/14927713.2017.1414626&loc=adaptor.primo\\_central\\_multiple\\_fe&vid=44UOE\\_VU1&tab=default\\_tab](http://discovered.ed.ac.uk/primo_library/libweb/action/diDisplay.do?docid=TN_tayfranc10.1080/14927713.2017.1414626&loc=adaptor.primo_central_multiple_fe&vid=44UOE_VU1&tab=default_tab)

The human resources management of a democratic action: intentionality, elements and functioning

[http://discovered.ed.ac.uk/primo\\_library/libweb/action/diDisplay.do?docid=TN\\_proquest1979918515&loc=adaptor.primo\\_central\\_multiple\\_fe&vid=44UOE\\_VU1&tab=default\\_tab](http://discovered.ed.ac.uk/primo_library/libweb/action/diDisplay.do?docid=TN_proquest1979918515&loc=adaptor.primo_central_multiple_fe&vid=44UOE_VU1&tab=default_tab)

Appendix 30-Bilingual (English, Malay, Chinese and Tamil)  
Pamphlets: Managing your stress effectively

**What to do when you are ANGRY?**

- ☑️ **Calm down** – breathe in and exhale slowly
- ☑️ **Identify the cause of your anger**
- ☑️ **Seek the advice of others**
- ☑️ **Withdraw to another place to control your anger**
- ☑️ **Discuss your problem with family member or friend**
- ☑️ **Assure yourself to forgive quickly and accept the fact that people make mistakes**

**Perform the 10B**

- ☑️ **B**e calm
- ☑️ **B**reathe in deeply
- ☑️ **B**ey: Just relax...
- ☑️ **D**o good deeds or nice things for people
- ☑️ **S**peak to someone
- ☑️ **H**ave a massage
- ☑️ **R**eat and listen to music
- ☑️ **P**erform physical activities
- ☑️ **E**xercise
- ☑️ **T**hink positive

**Managing your STRESS Effectively**

Published by:  
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Ministry of Health Malaysia  
016-33550000  
www.kemkes.gov.my • www.moh.gov.my

**Apa yang harus anda lakukan apabila anda MARAH?**

- ☑️ **Berhenti**... tarik nafas dan lepas pernafasan-leluhan
- ☑️ **Kenalpasti** punca anda marah
- ☑️ **Mencari** tempat orang lain
- ☑️ **Berbicara** ke tempat lain buat mengawal keseronokan
- ☑️ **Berhenti** dengan ahli keluarga atau rakan
- ☑️ **Membincakan** diri memajukan dan menafikan bahawa masalah juga melakukan kesihatan

**Amalkan 10B**

- ☑️ **B**erhenti
- ☑️ **B**erhenti dengan dalam
- ☑️ **B**erhenti : Pelekatlah...
- ☑️ **B**erhenti
- ☑️ **B**erhenti dengan seseorang
- ☑️ **B**erhenti
- ☑️ **B**erhenti dan mendengar muzik
- ☑️ **B**erhenti
- ☑️ **B**erhenti
- ☑️ **B**erhenti positif

**Menangani STRES Dengan Bijak**

Ditulis oleh:  
Bahagian Pendidikan Kesihatan  
Kementerian Kesihatan Malaysia  
016-33550000  
www.kemkes.gov.my • www.moh.gov.my

**கோபம் வரும்போது நீங்கள் செய்யவேண்டியது:**

- ☞ அமைதி காக்கவேண்டும் ... நின்று நிதானித்து மூச்சை உடனே திறந்து வெறுமனாக வெளியே விடவும்.
- ☞ கோபத்தினால் காரணத்தைக் கண்டறியவும்.
- ☞ பிறர் ஆறாவதுவகையில் நடந்து கொள்ளும்.
- ☞ கோபத்தைக் கட்டுப்படுத்த தேவநிதித் தொண்டர்கள்.
- ☞ குழி: உதவிக்கோர் அருங்கு தங்கியுடன் கைத்துறையாளர்கள்.
- ☞ பிறரை மன்னிக்கக் கற்றுக்கொள்ளவும் - தவறினதற்கு யாருமில்லை என்பது நினைவில் கொள்ளவும்.



**கீழ்க்கண்ட 10 வழிமுறைகளைக் கடைப்பிடிக்கவும்:**

- ☞ அமைதி காக்கவும்
- ☞ தந்திரம் இழந்து மூச்சு விடவும்
- ☞ "இது சில நாட்களில், இதைவிட வேறு ஏதாவது ஆட்டிவாங்குவேன்" என அடிக்கடி தள்ளுதல்களை செய்வதற்காகவும்.
- ☞ பின்புத்தலை: செய்வதற்கும்.
- ☞ பிழைகள் கைத்துறையாளர்கள்.
- ☞ உடல் பிடிப்பு (கைத்துறையாளர்கள்) செய்வதற்கும்.
- ☞ மூன்றாம் தரத்தினால் துன்பம் செய்யும்.
- ☞ பிழைகளை வெறுமனாகவே செய்வதற்கும்.
- ☞ உடல் பிடிப்பு: செய்வதற்கும்.
- ☞ தனித்தனியே நடக்கும் எல்லா நடவடிக்கைகளும் இறக்கவும்

**உங்களுடைய மன உளைச்சலை திறமையுடன் சமாளித்தல்**



## 当您生气时， 应该做些什么？

- ④ 冷静下来... 用力吸气，然后缓缓呼出
- ④ 确定生气的原因
- ④ 寻求他人的劝告
- ④ 到其他地点以控制怒气
- ④ 与家人或朋友讨论问题
- ④ 采取宽恕态度，接受人难免犯错的事实



## 实践10B的方式

- ④ 冷静
- ④ 深呼吸
- ④ 对自己说：放松一点...
- ④ 寻求宗教寄托
- ④ 向人倾诉
- ④ 按摩
- ④ 休息及听音乐
- ④ 做体操
- ④ 做运动
- ④ 正面思想

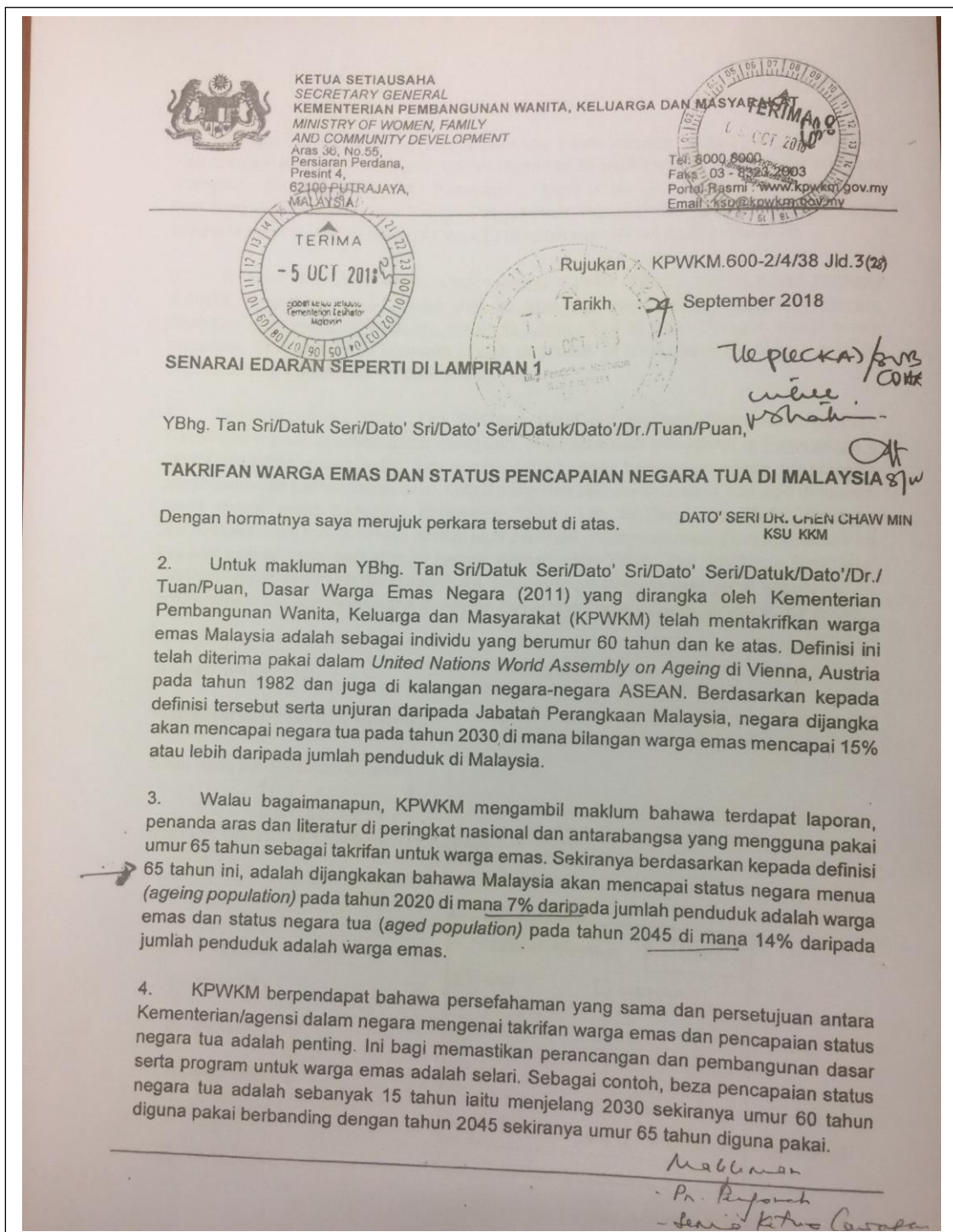
## 高效 管理您的 应力



Ministry of Health  
Kementerian Kesihatan Malaysia  
0884200000/0112  
www.kemkes.gov.my • www.moh.gov.my



**Appendix 31-Letter of announcement from Ministry of Women, Family and Community Development about the decision on onset of old age for Malaysian population**



5. Dalam hal ini, satu mesyuarat bersama pihak berkepentingan yang melibatkan Kementerian Kesihatan Malaysia; Kementerian Hal-Ehwal Ekonomi; Jabatan Perangkaan Malaysia (DOSM); Jabatan Kebajikan Masyarakat; Lembaga Penduduk dan Pembangunan Negara; dan Institut Penyelidikan Penuaan Malaysia, Universiti Putra Malaysia telah diadakan pada 14 Ogos 2018 untuk membincangkan perkara ini.

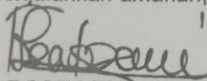
6. Mesyuarat telah bersetuju untuk mengguna pakai definisi warga emas sebagai mereka yang berusia 60 tahun dan ke atas dan mengiktiraf bahawa Malaysia dijangka akan mencapai negara tua pada tahun 2030 di mana bilangan warga emas mencapai 15% atau lebih daripada jumlah penduduk di Malaysia berdasarkan kepada definisi tersebut serta unjuran daripada DOSM.

7. Sehubungan itu, YBhg. Tan Sri/Datuk Seri/Dato' Sri/Dato' Seri/Datuk/Dato'/Dr./Tuan/Puan adalah dimohon untuk mengambil kira keputusan mesyuarat di **Perenggan 6** dalam sebarang penggubalan dan pembangunan dasar berkenaan warga emas serta penyediaan dan penerbitan laporan, nota ikhtisar dan percakapan, serta apa-apa dokumen rasmi dalam masa hadapan. Kerjasama YBhg. Tan Sri/Datuk Seri/Dato' Sri/Dato' Seri/Datuk/Dato'/Dr./Tuan/Puan adalah juga dimohon untuk memanjangkan keputusan ini kepada agensi yang berkaitan di bawah Kementerian YBhg. Tan Sri/Datuk Seri/Dato' Sri/Dato' Seri/Datuk/Dato'/Dr./Tuan/Puan. Sebarang pertanyaan mengenai keputusan ini boleh dirujuk kepada Setiausaha Bahagian Dasar dan Perancangan Strategik, KPWKM.

Sekian, terima kasih.

**"BERKHIDMAT UNTUK NEGARA"**

Saya yang menjalankan amanah,

  
(DATUK DR. ROSE LENA BINTI LAZEMI)

**Salinan kepada**

- 1) TKSU(S)
- 2) TKSU(O)
- 3) SUB (BDPS)
- 4) SUB (BKS)
- 5) SUB (BHA)

PEJABAT TKPK(KA)		TERIMA
<input checked="" type="checkbox"/> PBPKK	<input type="checkbox"/> AKAUNTAN	
<input checked="" type="checkbox"/> PBKP	<input type="checkbox"/> PPT	
<input checked="" type="checkbox"/> PBPK	<input type="checkbox"/> PA	
<input checked="" type="checkbox"/> PEP	<input type="checkbox"/> Makluman/Fail	
<input checked="" type="checkbox"/> PBPKA	<input type="checkbox"/> Sila Oncong	
<input type="checkbox"/> PEG KHAS	<input type="checkbox"/> Turutaka	
<input type="checkbox"/> Sila Wakil/Hadir		
Catatan: _____	<i>Mute Makluman Senma</i>	

2

DATO' DR. CHONG CHEE KHEONG  
(NO. MPM 26477)  
TIMBALAN KETUA PENGARAH KESIHATAN

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