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In memory of Marti G Parker

A member of the IJAL board, Marti Parker has passed away after prolonged illness. Marti Parker was professor of social gerontology at the Aging Research Center in Sweden. Her work was at the forefront of research on the connection between older people s function, health, and social and physical environment. Her analysis of socioeconomic differences in physical function was groundbreaking, demonstrating that the effects of socioeconomic position on function reach far into old age for both women and men. Our thoughts and deepest sympathies go to her family.

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Determinants of resilience for people ageing in remote places: a case study in northern Australia

*By Heather Gibb**

Abstract

The purpose of this study was to investigate how people managed to stay resilient as they aged in remote places. In Western developed countries, "successful ageing" is associated with older people's right to age in their chosen place. To remain resilient, older people require support to supplement diminishing self-reliance associated with increasing frailty. Such support services do not extend to remote communities, making it difficult to age in place. This article reports on a case study of ageing in remote places, from the perspective of seniors within a small community in remote northern Australia. The study found how older people attempt through volunteer efforts, to supplement the gaps in aged support services. This collective effort to achieve ageing in place demonstrated greater integration with place and social resilience within the community. However, seniors' social resilience was seen as tenuous, given collective self-reliance is based on volunteer efforts of older people.

Keywords: ageing, rural and remote, resilience, ageing in place, aged care services.

*Heather Gibb, College of Indigenous Futures, Arts and Society, Charles Darwin University, Darwin, Northern Territory, Australia

Introduction

This article reports on a case study of ageing in remote places from the perspective of seniors within a small community situated in remote northern Australia. The aim of the study was to seek an understanding, using an interpretive grounded theory method, of how people were growing old and managing to remain in a place of their choosing, despite there being no formal services to support ageing in place.

In Western developed countries, the phenomenon of population ageing is generating discussion about what it means to age successfully. The concept "successful ageing" is increasingly becoming synonymous with independence and choice (meaning physical self-reliance) (Stones & Gullifer 2016). Governments in Western countries have generally adopted neoliberal health and social policy that favour this discourse (Anderson & Kvist 2015). A major driver of neoliberal policy is concern with the costs associated with an ageing population and the projected growing demand on aged care services. A way around this rising cost is to promote strategies of self-reliance amongst older people. Advances in health and medical sciences have helped shape perceptions of the ideal older age as preserved health and an active lifestyle, continuing further into older age (Stephens et al. 2015). However, this ideal then becomes internalised as cultural markers by which older adults define the success of their own ageing and their identity (Keating 2008a; Tuohy & Stephens 2016).

"Healthy ageing" programmes create a normalised standard of success defined by the body defying deteriorating changes or postponing changes normally associated with the ageing experience. It ignores the role of genetics and social factors in contributing to health and activity status in later life. "Active ageing" normalises success through social participation and activity that leads to the preservation of autonomy and self-determination. These programmes form part of the politicised discourse that, it is argued (Jones & Heley 2016; Stephens et al. 2015), has the effect of placing expectations squarely on older people to preserve their independence and manage indefinitely, the challenges encroaching on their health, thereby avoiding adding to society's ageing problem of increasing rates of social welfare dependency.

However, there is a tension in this discourse. For people to successfully age – maintaining health and remaining active – they require not merely physical endurance that defies the vicissitudes of getting older but also the social and physical supports within their environment to supplement their growing limitations (Scharf & Bartlam 2008). This includes the availability of resources that sustain older people's capacity to meet physical and psychological changes as they happen and to adapt in order to remain independent (Stones & Gullifer 2016). This article examines the tensions within the successful ageing discourse, as it applies to the context of isolated rural or remote communities. In these contexts, neoliberal government policy on successful ageing harnesses expectations within theories about what constitutes successful ageing. However, it fails to advocate the kind of support required to maintain capacity for successful ageing (see Keating 2008b; Skinner & Hanlon 2016a).

Our discussion sketches the landscape of remote ageing in extreme climate conditions in Australia, comparing results from a small case study in tropical northern Australia with findings from research in other "extreme climate" contexts in Canada and northern Europe. It looks at considerations of the impact of lack of systems of support on seniors' ability to age actively in remote environments. In these small communities, unique scenarios of seniors' volunteer capacity (Hanlon et al. 2014; Skinner et al. 2014) belie the fragility of community resilience, which fades as these people grow older and can no longer care for themselves or each other. The long-term waning of resilience in these communities means the final cost – both fiscal and social, for governments and society generally – is substantial when the independence of these communities of seniors gradually disintegrates.

Ageing in Remote Australia

Our research was conducted in the Northern Territory (a central region of northern Australia), which has a population of approximately 240,000 residents, a third of whom are Indigenous. About half of these people live in sparsely populated regions, with a population density approximately 0.2 persons per square kilometre (Taylor & Payer 2017).

Since the mid-1990s, there has been a marked increase in the number of people aged 65 years and over in this region, from 4337 in 1991 to 16,815 in 2015 (ABS 2016). The population of residents aged 65 years and over is projected to grow from 13,000 in 2011 to 46,000 by 2041. The very old population (those 85 years and over) is projected to grow from just under 2000 residents in 2011 to just under 14,000 residents in 2041 (Taylor & Payer 2017).

Historically, the trade and prosperity of Australia's Northern Territory relied heavily on primary industries leading to population growth in inner geographical regions. In particular, the growth of mining and resource extraction industries led to a growth in service towns across this region of Australia. The towns were essentially purpose-built to suit the needs of the local mining industry. However, in recent decades, in response to shifting global commodity demands, the mining industry has undergone downsizing and workforce populations have fallen in remote towns. This has left both a glut of cheap housing and an ageing population (Skinner et al. 2014; Zeng et al. 2014), as younger people move out in search of work elsewhere. This leaves older people without younger family members to take care of them as they grow older and frailer. Population ageing is happening faster in these isolated rural communities than elsewhere (Keating 2008b; Skinner & Hanlon 2016a), creating what has been referred to as the neglected contexts of ageing (Skinner & Hanlon 2016b).

Hanlon et al. (2014) describe a scenario common across Canada, Australia and other developed, resource-dependent countries (see also Skinner & Joseph 2011, for a similar account of ageing rural communities in New Zealand). These are resource frontier towns and hinterlands that are isolated from services provided in larger urban centres (hospitals and specialist medical care, supermarkets supplying relatively cheap food and essential items). A familiar scenario is the closure of mines or other resource industries in their region, along with the cessation of services (public transport, banking and post, community centres and public libraries). In addition, there is the exodus of the community's youth in response to local unemployment.

In Australia, communities are defined in terms of remoteness using the ARIA index (ABS 2011). The region under study is classified as remote due to its location at considerable distance from a populated locality or service centre. Moreover, during the wet season, it can be cut off from accessible road transport.

Although there has been some interest in learning about the plight of people ageing in parts of rural (or regional) Australia (e.g. Fiest 2016; Rogers et al. 2015; Taylor & Payer 2017; Winterton & Warburton 2014, 2016), very little has been done to directly understand the experience of growing older in the remote (or very remote) north. There are several possible reasons for this, such as cost and accessibility considerations in conducting research in these areas. The vast northern regions have a tropical climate with long periods of intense heat and humidity and periods of monsoonal rains, which, at times, block transport routes. It may also reflect a lack of awareness of the rate of ageing in remote communities. Most communities classified as remote experience lack of public transport, as well as unreliable communication networks.

The Australian government's policy for delivery of reliable, quality health care to remote and very remote communities (including Indigenous Australians who make up a relatively high percentage of the population in very remote northern regions) is inadequate by its own admission (RHSC 2011; see also NRHA 2011). Most remote communities have access to a remote primary health clinic. However, aged care services in Australia are generally provided by private or not-for-profit agencies that are located in cities and have a system of funded care designed for service delivery within an urban context. As such, this service model is not yet able to service remote communities (Productivity Commission. Caring for older Australians 2011), where complexity of service requirement is magnified by unique characteristics of these communities: small populations and difficulty of access. Access is exacerbated by frequent extreme heat conditions or during floods. As a result, older people who can afford to do so move to urban centres, at great distances from their community, family and friends, either to access community aged support or to enter residential aged care (Gibb 2017; Lindeman et al. 2017). This article argues that in Australia, policies governing practical servicing of the needs of aged people in these areas, supporting them to age in place, are virtually non-existent. This is a likely scenario globally. Given that ageing in remote regions in extreme conditions presents a relatively new problem for them, few developed countries have addressed the challenge of supporting these seniors to age in place.

This research article is an attempt to make a contribution towards the development of suitable policy directions for supporting ageing-in-place, through generating understandings of what it is like to be ageing within the remote northern Australian context. A case study of one remote community and the experiences of older people who choose to live there is included as a beginning step towards identifying unique features of the Australian context that will help refine understandings of the global ageing phenomenon. This case study is the first stage of a larger research work using a grounded theory design to understand the diversity of meanings behind the experience of growing old in remote places in Australia's northern regions. Our research inquiry revolved around the relationship between resilience, ageing and living in a remote place. Our particular research questions were as follows: (1) *What are the determinants of resilience for older people in this remote community?* and (2) *What is the relationship between resilience, ageing and this particular remote place?*

The Reality of Ageing in a Remote Place

Ageing in place has been defined as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level" (CDC 2013).

There is overwhelming evidence that it is a preference of older people to remain in their own homes and age in place (e.g. Kendig et al. 2017; Stones & Gullifer 2016). This is exemplified in the growing appreciation of the relationship between ageing, place and community and its impacts on well-being (Wiersma 2016).

Temporality and place intersect dramatically, shaping meanings of growing old. With passing time, the capacity to follow a preferred lifestyle changes, along with the changing body, changing social connections, changing psychological strength and shifting identities of the self. The place one chooses to age in – normally one's home or one's community – is, at one time, a family and social hub. It may then take on meanings of solitary familiarity and comfort, evoking memories that reconfirm meaning and purpose. With changing time, the same place may require effort, challenging the person to confront loss, limitation and life's transformation. How well people transition these changes depends upon their resilience and the supports available to help them adapt to change. Van Abbema et al. (2015) identify protective or adaptive behaviours in older people as requiring both internal personal resources and external support resources.

In isolated rural and remote environments, it is not easy to access the appropriate resources to assist transitions. Resource needs change over time and are dependent on the particular environment. They relate to the unique characteristics of the person and the unique relationships that ageing rural people forge with place (Daly & Grant 2008). It is this diversity in resource need and flexibility in its delivery that Keating et al. (2013) argue really determines what makes an age-friendly community.

Ageing People and Ageing Places – The Importance of Volunteering

Ageing in many rural communities is supported by an immense willingness of older people to participate as volunteers to supplement services that are not there (Gjertsen et al. 2016; Rozanova et al. 2008; Taylor & Payer 2017). In many of these reported cases, the volunteer work of retirees has served to reinvigorate the community economically and socially. Increasingly, however, the era of austerity and cost-cutting measures by governments are pushing out welfare responsibilities to community, with policy moves in the UK, Canada and other developed countries to mobilise the volunteer sector in the social care of older people (Jones & Heley 2016; Milbourne 2016; Skinner & Joseph 2011).

For the volunteer movements in already service-depleted rural communities, it is to some extent "business as usual." However, the redefinition of the community's roles in providing social care within neoliberal health and social policy means volunteering becomes an obligation rather than choice for retirees (Jones & Heley 2016). It has no consideration of the impact of choice and motive in an older person's participation in volunteering, nor does it allow for diversity of age, resilience and physical well-being as variables impacting on people's capacity to volunteer.

Resilience and Well-Being in Older Age

Resilience is defined as "flourishing despite adversity" (Stephens et al. 2015), whereas well-being is used here as meaning an enduring sense of happiness or efficacy (van Abbema et al. 2015). Resilience is a consequence of sustained well-being and relates to capacity to endure. Heralded as an ideal state to accomplish, this discourse can, however, serve to normalise individual responsibility to maintain well-being and to be self-reliant, irrespective of the types of adversity they may face. In other words, theories of resilience that do not consider the impact of available support and opportunity on a person's capacity to thrive in older age, stigmatise people who fail to thrive due to lack of personal health and support resources.

A more considered view of resilience is a capability approach (Sen 1987, cited in Stephens et al. 2015), which considers resilience in relation to a person's own values and their particular understanding of what it means to age healthily. Resilience is defined therefore as the capability to achieve certain functions a person values within their particular personal circumstances and social environment (Stephens et al. 2015).

Another approach is to view resilient ageing as "resourceful ageing" (Reynolds 2015), which emphasises the importance of investing in people's capacity and the resources they are able to use to sustain them during hardships. This is a dynamic approach, which accords with a model of resilience in older age, based on adaptation to adversity through protective internal and external resources (van Abbema et al. 2015). It implies that people are able to continually learn, grow and strengthen their own resource base, providing they live within an environment that provides external support resources that nurture the development of inner resources. According to van Abbema et al. (2015), it is on this platform that older people are able to maintain physical and psychological functioning that facilitates a sense of thriving. This implies a strongly preventative and primary health direction for ageing services, rather than a more common medicalised approach (Stephens et al. 2015). This has been the approach taken by the WHO in launching the age-friendly communities' campaign – creating settings or supportive environments in which older people can flourish (Eales et al. 2008).

Finally, Welsh (2014) suggests developing understandings of community resilience. Gale and Bolzen (2013) have applied a similar conception in their research with Indigenous Australian youth. They chose to adopt social or community resilience as a more sensitive methodological concept than resilience as an individual quality. This constitutes a shift towards recognising the centrality of relations and cultural context as resources critical to a persons' ability to maintain well-being.

Resilience in a Remote Community of Older People – A Case Study

Our use of a grounded theory approach acknowledges diversity as an important component of theorising human experience as a function of the impact of environment on experience. Methodologically, it requires that the sampling for information gathering takes place across all variations of *remote place* including different population cohorts, in order for researchers to refine theoretical understandings of a concept such as resilience, with inputs from all possible sources of that experience.

Researchers who study human ageing and ageing communities emphasise the diversity of experience as a function of one's relationship with the place in which one lives (e.g. Keating 2008a; Keating et al. 2013). Diversity is extensive across the resource frontiers of northern Australia. Former mining towns are populated by people of largely European descent, along with Indigenous people who have settled in towns away from traditional homelands. Each of these groups may have been settled in this community or on the lands surrounding the township for several generations, or they may have recently relocated there for social reasons or employment. Then, there are Indigenous families who live in their traditional homelands, in the most remote and least accessible regions of the north. People are ageing in each of these contexts, and each cohort contributes a unique understanding of ageing in remote places in Australia.

The case study reported here is an investigation of the meanings of ageing and determinants of resilience within the perspective of the first of these cohorts – Australians of largely European heritage. Data that represent the perspectives of older Indigenous people, either those who have settled in remote towns or those living within traditional homelands, are currently being gathered.

Methods

Setting

The study was conducted in a region classified as remote, south west of Darwin. Out of a population of 1105 residents (ABS 2011), 112 residents were 65 years or over in 2011, with another 108 aged between 60 and 65 years. Members of this community were approached through the local branch of Council of the Ageing, Northern Territory (COTA, NT), and invited to participate in the research. A "snowballing" method was used to invite other older people to participate in further interviews. Initial meetings and follow-up discussions were held in the local bowls club room, in the town that will be referred to by the pseudonym "Acacia."

Participants

Fourteen senior members of the community in and around Acacia participated voluntarily in an interview of no more than an hour and a half in length. All participants, except one 61 years old, were between 65 and 80 years old. This younger participant took part together with her older husband for whom she acts as a carer. No participant identified as an Indigenous Australian, and no participant was living in the same region as their children or other close family members.

Process

All interviews were conducted, by choice, in their own or a friend's home. Six participants were interviewed individually. Eight volunteered as a couple, so they were interviewed as a couple. Ethics approval to carry out the research was obtained from the Charles Darwin University Human Research Ethics Committee. Interviews were recorded digitally, then transcribed verbatim by the lead researcher. Transcripts were sent back to participants for review. Some made significant changes to content, usually eliminating references to the lives of other people.

Once transcripts were reviewed and validated by participants, open coding was carried out using NVivo software for interpretive data analysis.

Interview quotations were organised into a hierarchy of thematic categories, which were then subject to a further level of interpretation via the use of axial codes (Charmaz 2014). This step in interpretive coding draws out relationships between categories and subcategories and specifies properties and dimensions of the relationship. The coding proceeds by asking questions such as "who, when, where, why, how and with what consequences?" (Charmaz 2014: 147). From this level of interpretive coding, one or more core categories are chosen, which "encapsulates and explains the grounded theory as a whole" (Birks & Mills 2015: 12).

Two follow-up focus groups were held over the following 6 months involving these participants, who also invited friends or spouses (three additional seniors), working over the themes and adding further focus and clarity to identifying major common concerns for the ongoing well-being of this community. Topics emerging as key concerns for further discussion were transport, personal care support (PCS) and respite care support.

Researchers and community members also met socially during these field visits and people informally shared perspectives on thoughts generated in the interview. These became the subject of social conversation akin to spontaneous "thought gathering." Community members also emailed additional thoughts that elaborated on their responses or on some thought that developed following our field visit.

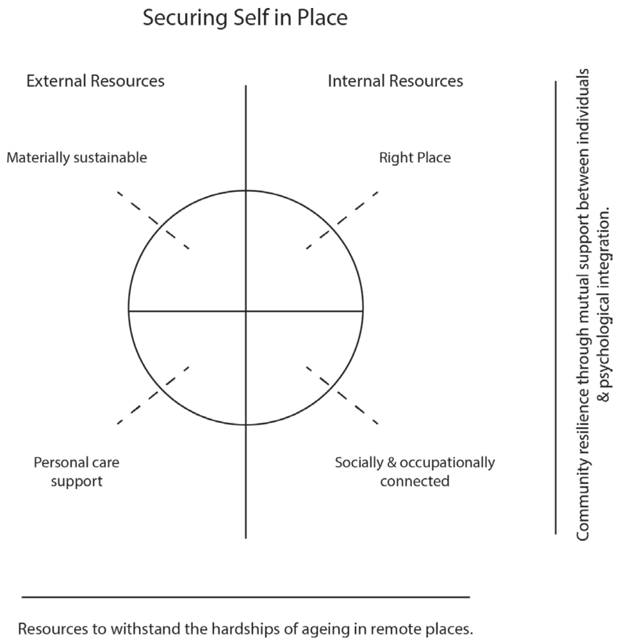
Analysis and Findings

The theoretical axiom emerging from the analysis of the textual data is "Securing Self in Place." *Securing self in place* refers to the capacity to remain living in a place of one's choosing, for as long as one chooses or prefers to live there. Although in the past there has been a view of ageing dominated by medicalised meanings – deterioration and dependency – the more recent discourses of well-being in older age shift the focus from dependency to active, self-determination about how one lives through older age. Within this framework, the importance of place and feeling secure within a place are key considerations. The responses of our participants capture the dynamic interaction of three concepts: the ageing self, security and place. The interaction of *ageing self* and *place*, which has been described extensively elsewhere (Keating 2008b; Skinner & Hanlan 2016a), is in our study, crucially mediated by the establishment of four theoretical "axes" relating to *securing self*, as shown in Figure 1.

Axis 1: Right Place

The first axis represents the "rightness" of the place chosen to live in. Hanlon et al. (2014) refer to this important connection as place integration (Cutchin 1997, cited in Hanlon et al. 2014): "The process by which individual sense of self becomes intricately bound to place and manifested in a commitment to overcoming the challenges of everyday life."

Figure 1. Four theoretical axes that constitute the meaning of Securing Self



This connection is primarily established through the alignment of several factors (see three subcategories below) and carries a strong sense of positivity and contentment.

Three conceptual subcategories of meaning contribute to the sense of this being the right place (RP). Below are supporting verbatim quotations from participants identified by a number (e.g. P1) and gender (M = male, F = female).

Emotionally RP was linked to the feeling that this is the RP: *Lovely little green place, lovely people, friendly people* (P1, M); *Yes you go a bit Bush happy here I suppose* (P2, M). It was linked to practical material characteristics of the place that are attractive to retired people. It is a healthy environment: *As you come past here, there is a bore, beautiful water* (P1, M). *It is a safe place: I have been able to go out and not lock my doors. There's virtually no crime here* (P3, F).

A sense of community was an important part of the feeling that this was the RP. Community contributed to the emotional connection with place: *...we made friends, we found the social energy of the community here was so great* (P4, F); *A community is close at hand: There's the Bowls club, Men's shed there; we've got our exercise classes. Everywhere you go, you meet someone you know to talk to. We've got a good library* (P5, F).

Belonging to place meant that people had a sense of being anchored, enabling them to feel energetic and useful, but also accepted: *It is my country and I didn't ever want to leave it...* (P6, F); *This is my adopted country; I made that decision sometime ago, that this would be my territory* (P7, M). This place enabled one man to feel a sense of freedom to live more authentically: *It is living, it is actually in a sense a contract you make within yourself, if you like. About where you belong and that you're going to live your life rather than prepare for some life in the future* (P7, M).

Axis 2: Socially and Occupationally Connected

The second axis was the sense of being socially and occupationally connected through community (SOC). This involves a sense of purpose, which is essential for well-being to be maintained through older age (Lewis 2014; Ryff 2014).

Several people spoke about the intensity of the social connectedness in the community, both long-stay families and new in-migrant retirees: *And then we started to get involved with community. And the community actually got involved with us* (P4, F); *you know if you join some organisation and you've been there two weeks and the AGM turns up, and oh, you've been here forever. So you can be the president, yes* (recent in-migrants) (P8, M). For these new community members, initiation was often prompted through story telling: *And we got all these lovely stories and I would just sit there mesmerised, you know, listening to the history of the place* (P9, F). However, belonging together was most poignantly regarded as sharing the same hardships: *We are all battling the same lack of facilities. And we are doing it in the only way we feel comfortable with* (P3, F). The most common "battle" was named as trying to stay in this place as they confronted older age.

Hanlon et al. (2014) have argued how intense place attachment emerges through participation in community work in response to the problems brought up through living in that place. Here in this remote town, the need for each person to be able to age in place is a collective galvanising point for volunteer activity. The community connection arising out of shared "battling" may well be a contributing factor to the intense positive feelings these people have towards the place.

Volunteering

Older people who valued this connection gave unconditionally of their time and effort to maintain the fabric of this belonging: *So, I actually offered them to fill in any gaps that they required, to allow them to stay as long as they feel comfortable* (P1, M); *She knew I was a nurse. She rang me [and said], can you come and give me a hand* (P10, F). In doing so, they share the knowledge that their investment in volunteering to help others is a critical glue to this community maintaining itself: *And now I want to help these people, I want to be the next generation and I want to encourage another generation beyond that, to keep doing this, to keep the energy up because it works. It actually strengthens the community, brings us together. And we have a mutual cause and it's not necessarily just survival. It's about quality of life in a remote area* (P1, M).

Volunteering amongst members of this community of seniors was most likely to be informal – helping each other on an individual level, as needs became evident. Senior community members often contributed their former occupational skills: plumber, school teacher, nurse, construction worker and public servant with knowledge about government departments. The age span was remarkable, with one 83-year-old woman still running music classes in the local school. The value of volunteering efforts of community members is in the way people work together, in a serendipitous way for the sake of community life: *And people just work together. They ring up and say I need someone to help me do this and there is a little bit of negotiation and it's fixed* (P9, F).

Some formally organised volunteering work existed, such as staffing the Tourist Information Centre in the town, as well as the establishment of an organised monthly community quiz night at the local bowls club and a weekly exercise class. Both of these community events were set up by in -migrant retirees. The two latter organised activities were established on principles of community capacity building – offering local people opportunity to develop skills in running the events, thus ensuring their sustainability. As the instigator of the quiz night event explained *...as my health* *deteriorated, I asked somebody who had been a regular, to co-quiz. And with that person's help, we've now got what we call pop-up quizzes, where anybody coming to quiz night can come with a round of 10 questions and do that at the night; it's along the lines of building the resource into the community and supporting people, to learn how to do questions etc. So they can be part of the quiz night* (P8, M).

The exercise class has drawn so much enthusiasm and interest, and it has been "cloned" to a neighbouring remote town: *To expand a little bit more on the energy that's there. I'll use the example of what I'm doing with exercise programs. There's a number of facets to this, but basically, it's about generating opportunities for people, particularly older people, to be involved in exercise. Last week was the first week of a new group in Casuarina (pseudonym for neighbouring town)* (P7, M).

The shared desire for community members to stay active and healthy, thereby ageing in place, provides an impetus for developing capacity to establish and expand programmes. This would ensure that ownership is vested in the community, not individuals: *...that enables you to sustain a locally energetic activity. And the same is true with the exercise group. I've now got two people who are right into yoga, who, if I can't be at the session we have here on a Tuesday night, I know that I can ask them to do it. And I've said to the people in Casuarina, that's where I want to be with this group over a period of time. But here it's taken eight years. We're not looking at a flash in the pan, 12-month program and stuff like that* (P7, M).

Several people described the added depth to friendships when people volunteer to work together for the sake of their community life. One example was a description given by a man who was a recent in-migrant, of his friendship through volunteering, with a long-stay resident as the latter was coming to terms with early signs of dementia:

> *He remembers very specifically he and I, and the therapy that we had with each other, just doing renovations in the museum buildings...You know he would put a tool down or you would ask him to go and get a tool and he would come back with something different. "B...Wow!" "Well, what did you ask me for?" And so we would go back through it again, but it was never a challenge. It was always a joke, it was always an issue, it was all therapy. I think he realised it was happening but it's like the rest of us, you know, we deny these things, and perhaps it's just the thought that maybe it's not really happening to us and maybe it would just go away and we'll all be ok* (P1, M).

Volunteering for the community was deeply valued and embedded in the local culture over generations, as described by a recent in-migrant: *This is their strength and their knowledge. They have built on that, to actually fill the gap of the facilities that weren't here. It is what their parents taught them, to fill the gaps that were required in this remote area* (P1, M).

Volunteering was like a bartering system that generated a sense of shared purpose. People felt obligated to pay back the help they were given, as a matter of self-respect: *But most people underneath, they have an obligation to pay back the favour, if not to that person, to at least someone else. I think that's what makes the energy go round* (P9, F). When these people were asked, why they invest effort later in life in helping others, the response has been that unconditional effort opens the community to you: ... *acceptance, appreciation, respect, and you don't need more than that. And generosity; friendship and respect* (P4, F). Moreover they saw generosity as an investment in building and sustaining mutual commitment – *that willingness to do it* (P11, M) – in a community that has to rely on itself.

Axis 3: Material Sustainability

The third axis, material sustainability (MS), carries the associated meanings of being able to provide for one's material needs adequately, including affordable housing and access to affordable food and clothing (this is not always achieved shopping locally). This theme of negotiating a way to sustain basic needs reflects the poverty threatening remote communities. This was a small category because people generally were not interested in dwelling on the need for frugality and going without. The fierce self-reliance ensured that material need was unlikely to be expressed: *And I think people we've grown up with are not looking for the great material things. And to live in an area of community where all this stuff is not laid on…everyone is on an even par, and we're all battling the same, you feel equal, therefore you all hop in together. I'm happy with a simple life. And that's why –the small community gives you a simple life* (P3, F).

MS referred to having the basics like affordable housing: *A few old people ended up in [Acacia] because houses were relatively cheap compared with Darwin* (P2, M).

Similarly, it was about being able to access reasonably priced food: *There's a general store in [Acacia] which provides necessities, but...people go ... to Darwin and buy their groceries rather than buy them from the [local]* *supermarket...if you're on a pension you can't afford to buy them from the [local] supermarket* (P12, F).

The need to be able to buy cheaper products in the city meant that transport was a high priority for older people ageing in this community: *The biggest thing I hear is people getting to town and back. We don't have a bus here. Even twice a week or something. If we had a bus, [that] ran from here to town* (P3, F).

Axis 4. Personal Care Support

The fourth axis was PCS requirements, meaning to have assistance when needed to be able to manage one's personal physical needs. People's vulnerability – not being able to manage one's personal care needs alone – is a common scenario that potentially faces them all. It was the most likely scenario that would force them to leave. The following is a quote from a woman whose husband has early dementia: *I used to always wonder why people lived here all their lives and went away down south in their retirement. And they used to say, there's no facilities up here for older people… [Our] intention was to stay here until our health was the thing that took us away and unfortunately, it's happened earlier than what we thought. And so we have to move… But it's very, very hard because my life is here* (P6, F).

Everyone interviewed shared stories about people for whom help was not reliably available: *We don't have the help and have to turn – when I was caring for my husband …he couldn't be left alone, because he used to fall. And I got offered maybe two hours once a month if I was lucky, to go shopping* (P3, F); *I know a couple of elderly gentlemen who lived in the flats in [Acacia]. They waited and the help [in personal care] never came* (P6, F).

RP and SOC contribute to forming a psycho-spiritual platform of security – which equates with internal resources, whereas MS and PCS together constitute a platform of practical sustainability – which equates with external resources. Our respondents' stories indicate that both kinds of security are needed to form an outlook of psychological well-being.

General Discussion and Conclusion

The significant relationship between ageing and place has received further validation in this study. Place constitutes a set of conditions for sustaining resilience, particularly psychological integration and belonging. Place also held strong emotional connection for these participants; as well as its natural beauty, what seemed to be most important was their own personal choice in being there. The degree of commitment to this place is comparable with the notion of "integration with place," which Cutchin (1997, cited in Hanlon et al. 2014) describes as occurring through shared opportunity to participate in solving practical problems affecting life, in that place. This case study has highlighted the relationship between holding place and securing a sense of self. It depicts the use of active agency in securing self through identifying and locating resources related to the four axes.

Psychological resilience has been described as a hardiness in the face of loss or social threat. It has been described as a personal resource comprising traits of self-reliance as well as equanimity (Mlinac et al. 2011). Although both these traits were evident from our interviews, seniors' accounts also included a strong altruistic trait, expressed through an interest in the well-being of others and activity undertaken, both as individuals and collectively, to ensure the safety and comfort of each other. Research in other community contexts (e.g. Hildon et al. 2010) has shown that social support is correlated with resilience. More specifically, socio-emotional support (not instrumental support) has been shown to contribute to higher quality of life for older adults (Netuveli & Blaine 2008). Another important trait that contributes to resilience in older age is a sense of worth and purpose (Clark et al. 2011). Our findings indicate that the opportunity to derive purpose from supporting others may contribute to resilience for older people in remote settings.

Resilience also relates to communities, in particular their capacity to collectively galvanise resources to withstand common stressors (Hochhalter et al. 2011; Vaneeckhaute et al. 2017).

Community or social resilience is often described using metaphors of resilience in physical systems derived from physical sciences such as engineering: Within a physical system, resilience connotes the capacity to accommodate, adapt or recover from stresses. Resilience refers to behaviours and activities that occur in response to the stress to withstand its impact and the consequences of those actions. The phenomenon of community resilience includes the strength of community capacity, which needs to be adequate to meet the force of the stresses – if not it reaches a point where community function will inevitably falter (Pfefferbaum et al. 2017). In our study of an ageing community, the absence of resources both to operate community facilities and to accommodate changing needs of individuals for support, indicates that a point will come where community capacity will not be able to accommodate the threats and challenges associated with collective ageing.

Collectively, the resilience of the community lies in being able to mutually negotiate the resources that van Abbema et al. (2015) have described as essential determinants of resilience. With these resources in place, capacity of the community would then be enhanced; people would stay and support the continued functioning of community enterprises. (The enduring industry in this town is tourism; these seniors operate both the information centre and the historical war museum – a significant tourist attraction.) In turn, servicing the needs of these people for ageing in place provides increased opportunity for local work and a service industry that would enhance "grey nomad" tourism in the region. This accords with Gale and Bolzen's (2013) conception of community resilience, where relations with other people and context or "place" are key determinants of resilience.

Just as in communities described in remote areas of northern Europe and Canada (Keating 2008b), this community is ageing, and its capacity to maintain what van Abbema et al. (2015) classify as external resources over time will diminish without added resources. In this study, all participants either owned their own home or had sufficient subsistence from the aged pension to pay rent and buy food. They also had access to free medical care for acute and chronic health conditions at their local remote health clinic. Moreover, our case study has indicated how exchange of mutual help assisted people locally to reach a basic level of MS. All this meant that the requirement of MS was adequately met (for a fuller discussion on the impact of low MS on the resilience of older people, see McMunn et al. 2006). PCS, however, was not and this was critical to these people being able to age in place. Unlike MS where people were reasonably self-sustaining, deficits in PCS constituted their greatest vulnerability, in this place. Without formal services of support, it was only a matter of time before people failed in their capacity to age in place. This vulnerability is discussed extensively elsewhere (e.g. Fiest 2016; Gibb 2016, 2017).

Resilience requires external supplementary resources; however, social resilience requires that these additional resources not take away the purposefulness, the "energy" of working for the community and providing mutual help that integrates person and place. Social resilience is a dynamic phenomenon. "Off-the-shelf" aged care packages are not the answer to the service needs of remote community members, as these threaten the subtle relationship older people have with other community members (mutual help) and with place (integration with place forged through attending mutual problems).

On its own, this study, limited as it is to one small community of seniors, is likely not to generate findings representative of other communities in remote northern Australia. Every community differs in its resources and its deficits in supporting ageing in place. However, the stories from these seniors provide a unique understanding of how resilience in one community is strengthened through mutual responses to the threat to securing one's life in a chosen place, with the advance of ageing and physical vulnerability. Service providers can apply this understanding at a general level in their approach to working with remote communities. When an inquiry is opened up about how to support community resilience in remote ageing communities, the appropriate response will always be about engaging with each unique community – not delivering an individual care package.

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Educational needs of Japan's dementia care workforce: results of a national online survey

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Abstract

Dementia prevalence is increasing in Japan commensurate with population ageing. This study addresses the paucity of research concerning the dementia education needs of Japanese health workers who care for older adults. A random sample of 117 aged care workers was generated from government lists of institutions and services across eight regions of Japan. Volunteer respondents completed an online survey concerning perceptions of dementia, professional educational needs and demographic information. Japanese aged care workers identified a high prevalence of dementia among their clients and acknowledged the value of professional education; however, they only reported moderate levels of dementia knowledge and confidence with care provision. Educational preferences included learning about non-pharmacological treatments for behavioural and psychological symptoms of dementia, workshop and mentor-based programmes, and incentivising education

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through formal certification and targeting content to professions. This research may inform the development of educational interventions for aged care workers, which may ultimately affect care for people with dementia.

Keywords: dementia, aged care, professional education, Japan, national survey.

Introduction

This research explores the dementia education needs of a national sample of aged care professionals in Japan. Aged care describes a sector of the health system wherein paid professionals provide support for frail older adults who reside in the community or in nursing homes. Professional (or continuing) education refers to work-related training undertaken following the completion of one's preparatory disciplinary education (Queeney 2010). In the health sector, ongoing training is essential to ensure that best-evidence care and treatment are available to health consumers. Education potentially improves the care and treatment practices of health professionals by increasing self-efficacy (self-belief or confidence) in their capacity to take action to improve patient health. This is consistent with social cognitive theory (SCT) (Bandura 1986), which identifies self-efficacy as a pillar of clinical action. To provide effective professional education, however, it is necessary to understand the needs of target cohorts and areas of societal and epidemiological concern.

In the 21st Century, dementia is emerging as one of the leading causes of death and disability in later life as individuals live longer than ever before (Ferri et al. 2006). Dementia is a progressive, neurodegenerative syndrome that is increasing in prevalence worldwide commensurate with population ageing (Kurrle et al. 2012). The clinical course of dementia varies considerably with physical, cognitive and behavioural symptoms that challenge diagnosis, treatment and care. While population ageing and advancements in preventive and curative medicine have triumphed over many of the maladies of the 19th and 20th centuries, a cure for dementia remains elusive. As there is currently no cure for the common forms of dementia, such as Alzheimer's disease and vascular dementia (Kurrle et al. 2012; Mitchell et al. 2009), it is necessary that health professionals understand best-evidence care and symptom management to provide patients with the best quality of life possible as the condition progresses.

As age is the primary risk factor for dementia, countries that are experiencing rapid population ageing, such as Japan, can expect significant increases in the prevalence of the condition in the coming decades (Ferri et al. 2006). Japan sits at the vanguard of population ageing due to historically low levels of fertility and mortality. In fact, it has been referred to as a super-ageing society due to the pace of demographic change relative to similarly developed countries (Muramatsu & Akiyama 2011). Muramatsu and Akiyama report that by 2030 one in every three Japanese people will be aged 65 years or older, while the Japanese Ministry of Health, Labour and Welfare (2014) estimates that there will be 7 million diagnosed cases of dementia in the country by 2050. Japan’s response to this challenge will arguably have global ramifications. Japanese experiences, policies and practices may inform strategies to respond to population ageing and dementia in other regions of the world. A recent observational study of Japanese aged care revealed that there are many world-leading approaches to the care of older persons within the Japanese health system that can inform global care practices (Annear et al. 2016d), including a focus on nutritional quality and physical rehabilitation. However, due to projections for unprecedented population increases in dementia and current high rates of Alzheimer’s disease and vascular dementia (Ferri et al. 2006; Meguro et al. 2002), measures are required to ascertain the educational needs of professional aged care workers as a precursor to the development of targeted education.

Internationally, there is growing evidence for the importance of professional education within the health and aged care sectors. Forsetlund and colleagues conducted a Cochrane review in 2009 to explore the findings of 81 randomised controlled studies of workplace educational interventions within the health sector (Forsetlund et al. 2009). Among their findings, Forsetlund et al. reported that mixed modes of professional education, including educational meetings and workshops, significantly improved health professional practice and patient outcomes. In 2006, Downs et al.

conducted a randomised controlled study in the United Kingdom to assess the efficacy of dementia education for improving detection rates in primary care settings (Downs et al. 2006). Downs and colleagues reported that both computer-aided educational tools and face-to-face workshops significantly improved the rates of dementia diagnosis across 36 practice settings. In a reflection on the state of international dementia education research, Rampatige and colleagues noted that while there is emerging evidence for the efficacy of multi-faceted interventions, such programmes must be carefully targeted to respond to the learning needs of professionals in different clinical settings and cultural contexts (Rampatige et al. 2009). It appears that there is no one-size-fits-all approach to dementia education and that research must be undertaken in local contexts to carefully elucidate educational needs and knowledge deficiencies before interventions are administered.

Although there is mounting evidence for the efficacy of professional education within the health and aged care sectors, limited research has been published on professional educational needs related to aged and dementia care in Japan. Such research is necessary in order to develop evidence-based and targeted interventions to improve health professional practice and patient outcomes. A scoping review of the Japanese literature was undertaken to identify studies of professional education in aged and health care settings that have been completed in the last two decades. Only six studies that considered educational needs of Japanese health professionals or students who work with older people were identified since 1996. The majority of the studies were aimed at elucidating the technical instruction needs of narrowly defined clinical practices (such as oral care techniques for older adults or use of geriatric assessment tools) (Misawa et al. 2014; Yoshiyuki & Kouno 2016) or conceptualising general workplace learning needs and experiences (such as professional coping in stressful environments) among health students (Kurabayashi 2014; Sakakura 1998), nurses (Furukawa et al. 2014) and clinicians (Honjyo & Komada 2015). No studies that directly addressed the mental health or cognitive care education needs of the Japanese aged care workforce in the last 20 years were identified. A recent study conducted by the authors examined Japanese knowledge of dementia among a sample of 185 health students and educators as part of pilot testing for a dementia knowledge scale (Annear et al. 2016c). This study revealed preliminary evidence for a low level of understanding about dementia and fundamental misconceptions concerning the clinical course of the syndrome, symptomatology and the efficacy of pharmacological interventions for behavioural symptoms (Annear et al. 2016c). Such results suggest that there is potential educational need among those who will comprise the dementia care workforce in the coming years in Japan. A more general study of perceptions of working conditions among those who provide professional aged care in Japan revealed respondents' concerns about their capacity for caring for patients with dementia, self-assessed limits in biomedical knowledge and a perceived lack of caring skills (Okada 2010). Among a series of conclusions, the author recommended increased workplace training for certified care workers in Japan (Okada 2010).

The existing literature suggests that there is a gap in the collection of information about the dementia education needs of Japan's aged care workforce. The present study, therefore, examines self-reported education needs among a randomly selected, national sample of Japanese aged care professionals. The results of this research are intended to inform future development of dementia education interventions for these professionals, which may ultimately improve care and treatment practices for people with the condition.

Methods

Design and Methods

Between 25 June and 25 October 2016, an online survey of aged care professionals in Japan was administered. The survey was prepared using the Google Forms online platform. With the growing ubiquity of internet access, particularly in more developed countries, utilisation of online surveys as a replacement for paper or telephone surveys is increasingly common in health research (Smith et al. 2007). This mode of survey administration creates both challenges and benefits for researchers that should be weighed prior to administration. Perceived challenges include possible differences in responses among individuals with higher and lower levels of computer literacy, expectations for a lower overall response rate and concerns about reliability, validity and data security (Fricker et al. 2005; Shih & Fan 2008). Specific advantages of online surveys include higher rates of survey completion (where non-response can often be avoided through programming), cost and time savings compared to the use of mailed or telephone surveys, wider dissemination possibilities across large geographic areas, higher data quality as manual entry and associated error is unnecessary, and perceptions of greater anonymity in response (Smith et al. 2007; Van Gelder et al. 2010). Reasons for using an online survey in the present research included the accessibility of the approach for collaborative survey development, pilot testing and international administration, as well as expectations for higher rates of data quality (with no need for additional data entry). Due to the national scope of our study, the online survey also reduced the time to send and receive responses among a Japanese sample, which was a relevant consideration in the context of a 4-month data collection window.

The online survey contained sections on experiences in the care and treatment of dementia, confidence with dementia care, preferences concerning dementia education and demographic questions. Examples of four questions that were posed in the survey include the following: 1) how would you rate your current knowledge about dementia? 2) How would you rate your level of confidence about providing care for a person with dementia? 3) In which topic areas do you need to improve your knowledge about dementia? 4) Thinking about professional education, what is your preferred type of learning environment? All these questions were administered in Japanese. Likert scale, multiple choice and dichotomous response format options were utilised. A full list of survey items is presented in Appendix 1. The research was led by an experienced gerontologist and dementia care specialist (MA) with support from a team of bilingual Japanese academics with expertise in nursing, public health and the human sciences. The study was reviewed and approved by the Osaka University Human Research Ethics Committee (KS1604).

Sampling, Selection and Recruitment

Publically available lists of aged care facilities and service providers are accessible throughout Japan and maintained by prefectural governments. Five facility and service typologies were sampled for the study from these lists, including special homes for older people (nursing homes); geriatric hospitals (specialist facilities for chronically unwell older adults); health facilities for the elderly (nursing care and medical management services);

respite/day services (short-term care support); and support/local management centres (community-based centres to support health management). These facilities and services represent the spectrum of long-term nursing care, specialist health care and community management for older adults who have diverse care requirements, including dementia. All geographic area typologies were included in the sampling frame of the study, including service providers in urban, regional and rural locations. Lists of aged care facilities were compiled for each of the eight regions of Japan using information from local prefecture governments. Within each of the eight regions of Japan, systematic sampling was used to randomly select 30 facilities from these lists. Facilities were then contacted by telephone by research assistants and a representative from the organisation was asked if they (or a nominated staff member) wished to participate in the study. Interested parties provided a contact email address for a clinical or administrative staff member. Occupational cohorts targeted in the study included a range of aged care professionals, such as nurses, care workers, physical therapists, clinical educators, trainees and administrative or managerial staff. Emails were then sent to potential respondents, providing information about the study and containing a link to the online survey. Potential respondents volunteered their participation and responses were anonymous. Respondents understood that consent for the inclusion of their data in the research was conditional upon their submission of the online survey.

Analysis

All analyses were conducted using SPSS (version 20.0) for Windows (IBM Corp 2011). Continuous data were initially screened for normality and the potential effects of outlier values, which revealed that the data were slightly negatively skewed, indicating the suitability of non-parametric tests of significance. Analyses were primarily descriptive, encompassing percentages and frequencies to elucidate dementia care experiences, educational needs and demographic information. Spearman's correlation was used to examine the potential relationship between self-reported knowledge and confidence in the care and treatment of dementia. Finally, cross-tabulations were performed to assess potentially significant relationships between previous dementia experiences (work, education and familial care) and self-reported educational needs (course content, learning typology and motivation).

Results

Sample and Response

In total, 197 aged care facilities provided contact details for staff members and indicated their willingness to receive email communication concerning survey participation. Among this cohort, 117 participants completed the online survey between July and October 2016, accounting for a response rate of 59%. No reasons were provided for non-participation as responses were anonymous once submitted online. The 5% trimmed means was checked against the true mean for continuous data and there was found to be no substantive influence from outlier values.

Concerning the demographic profile of respondents, the majority were from the Kansai region of Japan (encompassing the large cities of Osaka, Kyoto and Kobe), there was a relatively even gender split between male and female participants, and care workers were the most represented occupational cohort. Other occupational cohorts that responded to the survey are identified in Table 1, which include nurses, health students on placement, clinical educators, administrative and managerial staff, and other aged care workers (such as physical therapists). The majority of participants indicated that they had vocational or university training, previous dementia education experiences, and were directly involved in daily dementia care (see Table 1).

Educational Needs Analysis

National survey respondents reflected upon the prevalence of dementia in their workplaces and their experiences with professional education and dementia care and treatment. Respondents indicated that a large proportion of their clientele in aged care settings live with dementia. When estimating the prevalence of dementia, 76% of respondents considered that more than one out of every two of their clients experienced the condition. In the context of high levels of perceived dementia in Japanese aged care, there was also a high value placed on professional education, with the majority of respondents

Table 1. Demographic profile of respondents (*N* = 117)

Demographic information	Statistics
Regional locations of respondents	
Hokkaido	5 (4.3%)
Tohoku	3 (2.6%)
Kanto	16 (13.7%)
Chubu	5 (4.3%)
Kansai	80 (68.4%)
Chugoku	2 (1.7%)
Shikoku	3 (2.6%)
Kyushu/Okinawa	3 (2.6%)
Gender	
Male	61 (52.1%)
Female	56 (47.9%)
Age	
Mean age (Standard deviation)	56 years (5.68)
Minimum	47 years
Maximum	70 years
Occupation	
Medical student (workplace training)	1 (0.9%)
University academic (clinical educator)	1 (0.9%)
Nurse	6 (5.1%)
Care worker	74 (63.2%)
Other aged care staff	13 (11.1%)
Other (including managerial or service staff)	22 (18.8%)
Highest qualification	
Elementary school	1 (0.9%)
High school	14 (12.0%)
Vocational training	30 (25.6%)
University undergraduate degree	65 (55.6%)
University postgraduate degree	4 (3.4%)
Other	3 (2.6%)

(*Continued*)

Table 1. (*Continued*)

Demographic information	Statistics
Direct professional dementia care experience	
Yes	65 (55.6%)
No	52 (44.4%)
Previous dementia education experience	
Yes	69 (59.0%)
No	48 (41.0%)
Family member with dementia	
Yes	41 (35.0%)
No	76 (65.0%)

scoring the importance of continuing learning as "very important" (modal value of 5 on a 5-point Likert scale). In spite of the perceived prevalence of dementia and a high regard for professional education, self-rated knowledge of dementia and self-rated confidence in the provision of treatment and care were only rated as "moderate" (modal value of 3 on 5-point Likert scales). Correlation (Spearman) analysis of self-rated knowledge and self-rated confidence was undertaken. A statistically significant and strongly positive correlation was identified between self-assessed knowledge of dementia and confidence in the provision of dementia care and treatment among Japanese aged care professionals ($r = 0.76$, $p < 0.001$, $n = 117$).

Descriptive analyses of Japanese health professionals' dementia education needs revealed preferences for specific content, learning styles and motivation for participation. Among the desired content considered as important for enhancing understanding of dementia, the most frequently reported educational needs included learning about the non-pharmacological interventions for challenging behaviours (39%), dementia pathology (17%) and dementia causes and risk factors (12%). When considering the delivery of dementia education, the majority of respondents indicated their preference for learning in a group workshop or seminar setting (58%) followed by individual mentoring from a senior colleague or dementia expert (16%). Finally, when articulating their motivation for dementia education, the most commonly reported incentives for participation included accessing diverse content about the condition and its care (34%), recognition of learning and achievement in the form of certification (20%) and targeted content tailored to the needs of particular aged care professions (17%).

Finally, a series of cross-tabulations were undertaken to investigate potentially significant associations between previous dementia experiences and reported dementia education needs. A significant relationship was identified between prior dementia education and motivation for professional education. Respondents with previous formal dementia education experience expressed significantly greater motivation to undertake diverse education that covered all aspects of the condition than those who did not have previous education in this area ($p < 0.05$). Thus, previous dementia education appeared to act as a potential motivating factor for the intention to participate in future dementia training across a broad scope of the condition and its care and treatment. There were no significant associations between direct dementia care experiences or family care experiences and any modality of dementia education needs (Table 2).

Discussion

A dementia education needs analysis was conducted with a national, random sample of 117 aged care professionals from eight regions of Japan. Respondent cohorts represented in greatest number included individuals from the Kansai region, professional care workers and those with undergraduate or vocational qualifications. Many respondents also had previous experiences of direct dementia care, formal dementia education and family care for relatives with the condition – suggesting some level of pre-existing understanding prior to online survey participation. The majority of respondents (76.9%) estimated that 50% or more of their aged care clients had dementia, which indicates a perception of high prevalence of the condition within Japanese institutional settings. This estimation is congruent with known global prevalence within aged care settings reported internationally (Ferri et al. 2006) and the high incidence of the condition that has been reported in Japan (Meguro et al. 2002), although relatively limited research on prevalence has been conducted on populations older than 80 years who live in institutional settings (Dodge et al. 2012). It also suggests that dementia in Japanese aged care facilities is currently at a high baseline and that pressures associated with the condition can be expected to increase in the coming decades as Japan continues to age as a society. Understanding dementia prevalence is challenging as

Table 2. Dementia experiences and education needs (N = 117)

Dementia experiences and education needs	**Statistics**
Estimated proportion of clients with dementia (*n*)	
Less than 25%	4 (3.4%)
25–50%	23 (19.7%)
50–75%	28 (23.9%)
Greater than 75%	62 (53.0%)
Importance of professional/continuing education/5	
Mean (Standard deviation)	4.73 (0.54)
Median	5.00
Mode	5.00
Self-rated knowledge about dementia/5	
Mean (Standard deviation)	3.15 (0.67)
Median	3.00
Mode	3.00
Self-rated confidence in dementia care/5	
Mean (Standard deviation)	2.97 (0.74)
Median	3.00
Mode	3.00
Dementia education needs (*n*)	
Care for people with dementia	10 (8.5%)
Dementia causes and risk factors	14 (12.0%)
Dementia pathology	20 (17.1%)
Dementia symptoms	4 (3.4%)
Non-pharmacological interventions for behavioural symptoms	45 (38.5%)
Pharmacological treatment options for people with dementia	8 (6.8%)
Prevention of dementia	13 (11.1%)
Others	3 (2.6%)
Preferred learning mode (*n*)	
Group workshop or seminar	68 (58.1%)
One-to-one mentoring with a senior colleague or expert	19 (16.2%)
Self-paced online course	10 (8.5%)

(*Continued*)

Table 2. (*Continued*)

Dementia experiences and education needs	Statistics
Self-paced distance learning (not online)	2 (1.7%)
University or other tertiary institution classes	14 (12.0%)
Other	4 (3.4%)
Motivation for professional education (*n*)	
A certificate of completion or achievement	23 (19.7%)
Access to a group where I could ask students or tutors questions	4 (3.4%)
Content targeted to the learning needs of my profession	20 (17.1%)
Contribution to professional accreditation	2 (1.7%)
Multimedia content, including video and audio	11 (9.4%)
Diverse content covering all aspects of dementia treatment and care	40 (34.2%)
Regular tests/quizzes to check my progress	6 (5.1%)
Freely accessible content	11 (9.4%)

under-diagnosis of the condition is common, even in developed countries, and symptoms can often mimic other conditions, including depression or mild cognitive impairment (MCI) (Kurrle et al. 2012). Despite some uncertainty, projections for dementia in Japan suggest major increases in prevalence and incidence in the coming four decades (Dodge et al. 2012), which (in the absence of curative treatments) will necessitate improved awareness and understanding of the condition among the aged care workforce. The nature of dementia presentations in Japan may also be more complicated than in other developed countries, with evidence suggesting comparatively higher levels of vascular dementia in conjunction with already prevalent Alzheimer's disease (Ikeda et al. 2001; Yanagihara 2002). Thus, the future of dementia in Japanese aged care is likely to present unique challenges related to both an increasing prevalence and complicated presentation.

The online survey respondents were well educated, with 85% reporting that they had at least vocational training for work in aged care and 59% reporting that they were qualified with a bachelor's degree or higher. This high level of education, particularly at bachelor's degree level, potentially reflects the seniority of respondents within their organisations. Relatedly, the data revealed a significant association between previous dementia education (as part of course or workshop participation) and motivation for further professional education. It appears that professional education in the health sector may be a self-reinforcing or virtuous cycle whereby previous experiences of formal learning provide the impetus for individuals to seek out future educational opportunities (Wolters 2003). Relevant and best-evidence education in the health workplace may help to re-engage lower skilled workers with learning and support motivation by allowing them to experience achievement, self-efficacy, comradery and goal fulfilment (Keller 2008). Opportunities for professional education have previously been reported as an important factor in the retention of workforce participants in the health sector (Willis-Shattuck et al. 2008) where financial rewards are often lacking (particularly for lower skilled workers) and the demands of the role can be challenging. Turnover rates among aged care staff in many developed countries are typically higher than other sectors, and Japan is no exception to this. Government research indicates that one out of every five aged care workers in Japan leaves their organisation annually and 56% regularly consider leaving their job (Ministry of Health, Labour & Welfare 2016). Professional education in areas such as dementia care may help incentivise greater workplace engagement in this challenging environment.

Respondents placed a high value on professional education in the context of their roles within the aged care sector (modal score of 5 on a 5-point Likert scale). Considering the progressive, neurodegenerative course of dementia (Kurrle et al. 2012; Mitchell et al. 2009), it is understandable that continued learning in this complex environment was valued by health care workers. Emerging research concerning the efficacy of professional education about older adult health shows that workplace learning can improve clinical outcomes for patients. For example, a recent systematic review of educational interventions among clinical participants showed that singular or mixed modes of professional education (including courses, conferences, lectures, workshops, seminars and symposia) can facilitate significant, positive changes in learning and, consequently, improve patient outcomes (Forsetlund et al. 2009). Evidence from the United Kingdom also supports improved detection and diagnoses of dementia, with implications for improved care, following professional education among those who provide high levels of care for older adults (Downs et al. 2006). In countries such as Australia, dementia education programmes are well established with specialised courses offered at universities and by workplace education providers, including degree courses, massive open online courses, and dementia education and advisory services (King et al. 2014). While dementia education interventions are yet to be trialled with members of the aged care workforce in Japan, evidence from other developed countries in the Asia-Pacific region suggests that significant impacts on care and treatment behaviour and patient outcomes may be expected.

Despite a high regard for professional education among aged care workers, self-reported knowledge about dementia and confidence with care and treatment were only moderate (modal score of 3 on 5-point Likert scales), indicating respondents' reservations about their level of self-efficacy in effectively managing the condition in their workplace. There is a strong, positive correlation between self-rated knowledge of dementia and self-rated confidence in the provision of care and treatment. This aligns with the literature concerning SCT, which asserts that self-efficacy (self-confidence in clinical abilities) is an important attribute for determining clinical action taking (Bandura 1986, 2004), including the capacity to provide effective care for a person with dementia in an institutional setting. Although causality was not assessed in this study, it can be hypothesised that improving knowledge through professional education may have the capacity to enhance clinical self-confidence in the care and treatment of a person with dementia. This may potentially lead to better health and quality of life outcomes for people living with this degenerative condition. Internationally, there is evidence from medical education and dietetics that improving professionals' knowledge plays an important role in increasing self-efficacy (e.g. care and treatment behaviour) and that an increase in both of these parameters leads to measurably better care and treatment for patients (Ghaffarifar et al. 2015; Stark et al. 2011). Hypotheses concerning the potential outcomes of dementia education in the workplace should be tested with an educational intervention that examines baseline knowledge of the health care workforce, knowledge change following education and any resultant changes to clinical behaviour and patient outcomes.

When members of the Japanese aged care workforce reflected on their dementia education needs, preferences were identified for content, educational style and motivating factors. Aged care professionals showed preferences for learning a breadth of content about dementia with specific focus on non-pharmacological interventions for the management of behavioural symptoms. The mode of educational delivery considered most efficacious was a group workshop or seminar, potentially augmented with mentoring from senior colleagues or dementia experts. Finally, respondents indicated that participation in professional dementia education should be incentivised with the recognition of learning in the form of certification for course attainment and completion. Each of these preferences is considered below.

Aged care workers' preferences for learning about non-pharmacological approaches to the management of dementia-related behaviours reflect the challenges of caring professions. As dementia is a progressive, neurodegenerative condition that causes significant cognitive changes, challenging behavioural and psychological symptoms of dementia (BPSD) frequently result from the underlying pathology. Common BPSD include emotional disturbances, delusions and abnormal thought patterns, agitation or aggression, visual hallucinations, wandering and changes in sleep patterns and appetites (Cerejeira et al. 2012). All of these changes can prompt unpredictable behaviours in the person with dementia. Such symptoms create difficulties for carers and family members and may threaten the safety of those who provide support as well as the person with dementia. BPSD can be addressed with either pharmacological or non-pharmacological treatments. Pharmacological interventions for BPSD (particularly the prescription of antipsychotic medications) are known to carry significant risks and are associated with deleterious side effects, including stroke, delirium and death (Guthrie, Clark & McCowan 2010). For this reason, carers and family members are often interested in less harmful alternatives. Non-pharmacological interventions for BPSD are considered comparatively safer and involve a range of activities, communication strategies and counselling techniques that have proven efficacy in reducing the severity and frequency of BPSD (Douglas et al. 2004). Examples of non-pharmacological interventions that have been used to address BPSD include cognitive behaviour therapy, reminiscence therapy, environmental modification, support groups, music therapy, pet therapy, multi-sensory therapy, physical activity and others (Douglas et al. 2004; Janzen et al. 2013). Learning about such approaches can help aged care providers to support their clients with dementia without increasing the risks associated with medical management.

Japanese aged care professionals indicated that their preferred mode of education was group workshop or seminar and discussions with mentors or dementia experts. This suggests that respondents value education that can be provided at their place of work, face-to-face and in the context of other learners. Intervention research conducted in the United Kingdom has shown that participation in dementia education workshops undertaken at aged care facilities significantly enhances the rates of detection of dementia professional staff (Downs et al. 2006). Australian research has also shown that workplace dementia education improves knowledge and attitudes among clinical trainees, including medical and nursing students (Annear et al. 2016b). These findings suggest that connecting education with the direct experience of dementia care provides an optimal setting for learning. In Europe and Australia, teaching aged care facilities (TACFs) combine educational and institutional facilities to provide on-site learning opportunities for staff and trainees concerning geriatric health and care (Annear et al. 2014). Such facilities may also be effective in Japan, although there are currently no examples of the development or evaluation of such initiatives. Concerning preferences for collective learning, inter-cultural education research has previously reported that group activity is often preferred for learners from East Asian nations, including Japan, due to cultural preferences for communal activity, classroom harmony and shared learning experiences that reflect wider societal values (Nguyen, Terlouw & Pilot 2006). Respondent preferences for collective and interpersonal modes of workplace dementia education are also consistent with the reflective practice model of organisational learning (Schon 1983). Within this framework, researchers have asserted that collective work, peer dialogue and reflection on practice among those who provide aged care services can be more effective in facilitating learning than formal modes of education (Börjesson et al. 2015; Nishikawa 2011). The effectiveness of collective workplace learning is theorised to be driven by the value that care workers place on shared and co-constructed knowledge at their place of work as a uniting organisational force. This contrasts with the privileged knowledge of individual experts, which is sometimes perceived to undermine group learning (Börjesson et al. 2015). Japanese preferences for collective learning in the context of dementia education are potentially significant as increasing institutional endeavour has gone into the development of MOOCs. Such modes of education provide accessibility for distance learners and individuals without the means of attending university courses, but fail to account for preferences for and benefits of learning with peers in a group setting.

The final element of preferred dementia education addressed by Japanese aged care workers was the importance of incentivising education through recognition of learning (formal certification) and targeting content to the needs of professions (professional care workers, allied health workers, recreation officers, nurses, etc.). Globally, work in aged care settings is often characterised by low pay and status, manual labour, shift work, high staff turnover and limited opportunities for professional development (Annear et al. 2014; Hugo 2007; Ministry of Health, Labour & Welfare 2016). There are also persistent hierarchies within the health professions of many developed countries, which often unfairly subordinate and devalue nursing and caring roles within the health care sector and wider society (Walker & Holmes 2008). Providing formal recognition of learning through certification may help affirm the value of aged care professionals and provide them with a record of achievement to support their career development. Such strategies can play an important role in improving care worker motivation and, in turn, supporting better care for clients with dementia. Research conducted in Japan has shown that professional identity and image are important motivational factors for people who work in aged care (Hotta et al. 2009). Provision of certification for relevant learning may provide an opportunity to enhance identity for such workers and improve the image of the profession. As populations in more developed countries continue to age and expectations for quality of care in later life increase, there will need to be a commensurate increase in the value placed on those who provide care in institutional settings. The growing prevalence of complex conditions, such as dementia, will necessitate that the Japanese workforce is well versed in best-evidence care, appropriately compensated and valued by the health care sector and society.

Limitations, Implications and Future Research

The collection of national data from aged care facilities and service providers in Japan was not without challenges. A number of aged care facilities and service providers listed in each prefecture did not have a website or email contact information and the data presented herein represent a subset of aged care facilities that have access to electronic communication technology (a limitation of online surveys generally). Furthermore, the largest response cohort came from the Kansai area (encompassing the large cities of Osaka, Kyoto and Kobe). It was apparent from the contact between research assistants and potential respondents that there was a degree of provincialism in respondents' intention to support (or not support) research efforts from a large public university based in Kansai. As aged care providers within each region of Japan were randomly selected (using a systematic sampling approach), it was not possible to differentiate rural and urban professionals as part of the present analysis. Future research studies could implement a cluster sampling approach within each region of Japan to explore rural and urban differences in dementia education needs or dementia knowledge if significant geographic differences are hypothesised. Although a response rate of 59% was achieved in this study, work could also be undertaken to capture the educational needs of groups who are typically disinclined to participate in survey research, including those with lower levels of workplace self-efficacy, clinical expertise or education. Future in-depth research using interview or focus group methodologies among purposively selected aged care service providers may be helpful to fully assess the diversity of educational needs within the sector. In contradistinction to studies conducted in other developed countries (Annear et al. 2016a), the gender of respondents of this research was closely matched. This could indicate a more equitable gender balance in Japanese aged care when compared to other countries in which females are the dominant workforce participants (Alzheimer's Disease International 2015). This thesis, however, is not supported by Japanese government data, which show that females comprise up to 80% of professional carers for older adults (Ministry of Health, Labour & Welfare 2014) consistent with the proportion of the aged care workforce in other countries. The nature of the present sample may reflect the dominance of male professionals in senior clinical and administrative roles within the sector, making them more likely to respond to the online survey as a person of authority within their organisations. Due to the increasing demands for aged care in Japan, it is also likely that there will be growing demands for male participation in service industries that have traditionally been the preserve of female workers as the demography of Japan undergoes rapid change (Muramatsu & Akiyama 2011). Despite these limitations, this study is the first of its kind to use a diverse Japanese sample to ascertain the dementia education needs of a population of aged care workers at a time when the condition is growing in prevalence. The systematic sampling approach that was used across diverse facilities and service providers ensures a degree of representativeness, although replication with larger random samples is recommended to verify these results.

Conclusion

This study provides evidence of the dementia education needs among a national sample of Japanese aged care professionals. The data show that Japanese aged care workers consider dementia to be prevalent in aged care and value the role that professional education can play in enhancing their understanding of the condition and improving institutional care for their clients. When conceptualising their needs for dementia education, respondents require content that addresses a breadth of information about the condition (from risk factors and underlying pathology through psychosocial aspects of care). Of greatest concern for aged care professionals is a desire to improve their understanding of non-pharmacological approaches to managing the challenging behaviours associated with the progression of dementia. Professional education courses should be administered for greatest effect by utilising workplace workshops and seminars augmented with expert mentoring. Such education should also be incentivised by targeting workshops to the needs of specific professional groups and providing recognition of learning in the form of certification. This study represents the first time that professional dementia education needs have been described across the Japanese aged care sector. It is anticipated that these results will be used by academics, clinical educators and policy specialists to inform the development of workplace education programmes in the Japanese aged care sector that aim to improve care quality and treatment practices for people with dementia. As Japan is at the vanguard of global population ageing and as age is the greatest risk factor for dementia, responses to the prevalence of the condition in this super-ageing society will provide salient lessons for the rest of the developed world.

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Appendix 1. Dementia education survey items [translated from Japanese to English]

Survey item	Response format
Dementia education questions	
Have you ever provided professional dementia care to older adults within the aged care sector?	Dichotomous response (Yes/No)
Have you ever completed a professional training course on dementia?	Dichotomous response (Yes/No)
How would you evaluate your current knowledge of dementia?	Likert scale
How would you evaluate your level of confidence about providing care for a person with dementia?	Likert scale
What proportion of your patients who are aged 65 years or older would you estimate to have a cognitive impairment?	Multiple response option
What area do you consider as most needed to improve your knowledge about dementia?	Multiple response option
How important is continuing/professional education for your development as a health professional?	Likert scale
Thinking about continuing/professional education, what is your preferred type of learning environment?	Multiple response option
Demographic information questions	
Which geographic area of Japan are you currently working in?	Multiple response option
When is your date of birth?	Dropdown box selection (calendar)
What is your gender?	Multiple response option
What is your current occupation?	Multiple response option
What is your highest completed educational qualification?	Multiple response option
Have any of your immediate family members ever been diagnosed with dementia?	Dichotomous response (Yes/No)

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Number of roles and well-being among older adults in the Czech Republic

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Abstract

This article aims to analyze the relationship between number of roles, stress, and overall well-being among 50- to 70-year-olds in the Czech Republic and to assess whether this link can be at least partially attributed to other role-related factors, namely individual role types, role overload, and role strain. Using OLS regression, the number of roles was found to be positively related to both stress and overall well-being. The link between multiple roles and well-being among elderly Czechs was mostly irreducible to other role-related factors. However, some of the positive association between number of roles and stress was likely due to occupying a worker role, experiencing role overload and experiencing one role as particularly concerning or difficult, while some of the positive association between multiple roles and overall well-being was partially attributable to occupying grandparental and "active ager" roles.

Keywords: number of roles, stress, well-being, strain, enhancement, active aging.

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Introduction

Later life has often been characterized by an overall withdrawal from social roles (Adelmann 1994). Yet nowadays, many older people actually tend to occupy multiple roles – for example, due to their becoming grandparents while still fully engaged in paid work (Ochiltree 2006; Reitzes & Mutran 2004). From the perspective of active aging, multiple role occupancy in older age should foster well-being, as embarking upon numerous activities is believed to improve quality of life (Avramov & Mašková 2003; Uhlenberg 2005). On the contrary, a multitude of roles might also be a burden and a source of stress, especially as role accumulation may lead to role conflict and role overload (Adelmann 1994; Sieber 1974). The aim of this article is to analyze the relationship between number of roles and well-being among older adults using survey data collected in 2014 in the Czech Republic. This is, in part, a way to address existing gaps in our knowledge about roles in later life (e.g. Adelmann 1994). The exploratory analysis has two main aims: to examine the nature of the association between number of roles and stress, and number of roles and overall well-being in the population of older Czechs, and to assess whether this link can be at least partially attributed to other role-related factors, namely the specific types of roles a person occupies, role overload, and the experience of role-related strain. In the following part, I will first briefly overview the main theoretical hypotheses concerning the relation between multiple roles and well-being. Next, I will describe and analyze the data, and discuss the results.

Number of roles and well-being

In literature, two broad perspectives relating to the association between multiple role occupancy (or role accumulation) and outcomes such as well-being, stress, and health can be identified: (1) *the role strain hypothesis*, which predicts multiple roles to have a detrimental effect and (2) *the role enhancement hypothesis*, which argues in favor of a beneficial effect (summary, e.g., Adelmann 1994; Ahrens & Ryff 2006). The term "role strain" was first used by William Goode (1960) "to signify the difficulty of performing multiple roles, asserting that the resultant tendency toward strain is a ubiquitous feature of social life" (Sieber 1974: 567). Generally, strain is assumed to be the result of either conflict between roles, role overload (Adelmann 1994: S277), or perhaps the contagion of stress between roles in one's roles set (Bolger et al. 1989). Role conflict refers to conflicting expectations and demands stemming from different roles (Coverman 1989; Hecht 2001; Peterson et al. 1995; Reilly 1982; Sieber 1974). Role overload is understood as the situation in which one has too much to do and not enough time (or energy) to do it[1] (Coverman 1989; Hecht 2001; Pearlin 1989; Perry-Jenkins et al. 2007; Peterson et al. 1995; Sieber 1974). The perception of overload was theorized to depend upon the extent to which different roles are demanding – with people whose roles are less demanding being less likely to report role overload (Reilly 1982). Furthermore, an individual's commitment to various roles was also emphasized and Reilly (1982) warned against confusing low commitment with role overload (cf. Marks 1977).

The notion of the overall harmfulness of multiple roles (role accumulation, role strain) was contested by Sieber (1974), who argued that rewards and gratifications stemming from occupying multiple roles should outweigh any tensions brought about by role overload and role conflict. In his paper, he highlighted four groups of such rewards: (1) role privileges, (2) overall status security, (3) resources for status enhancement and role performance, and (4) personality enrichment and ego gratification. This means that multiple roles may bring benefits (rather than strain) by providing more rights and liberties to their incumbents; by providing buffers against failure or stress; by providing valuable resources, for example, in the form of social capital; and by enriching one's personality. Furthermore, role overload and even role conflict can in themselves be beneficial as they might generate the feeling of being needed. Moreover, "individuals are often esteemed solely by virtue of their possessing a wide repertoire of roles" (p. 576; cf. Nordenmark 2004).

Evidence regarding the impact of multiple roles on outcomes such as stress, well-being, and both mental and physical health has so far been mixed, but many findings lend support to the enhancement rather than the strain hypothesis (as summarized in Adelmann 1994; Ahrens & Ryff 2006; Coverman 1989; Hecht 2001; Hong & Seltzer 1995; Glynn et al. 2009; Nordenmark 2004). Adelmann (1994) nevertheless notes that, in many

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[1] The concept of role overload is not a straightforward one but its definitions tend to be based around "time" and "energy." However, Marks (1977) argued that as time and energy are both social constructs rather than objective limitations, role overload functions as a socially acceptable excuse for individuals uncommitted to particular roles.

instances, an inadequately small number of roles was used (usually three – employee, parent, and spouse). On the contrary, well-being might be affected by the quality rather than the quantity of roles (e.g. Baruch & Barness 1986; Nordenmark 2004), the meaning attached to roles by their holders (Simon 1995), or the particular role types present within the role set and their combinations (Hong & Seltzer 1995). Other authors have also suggested that the subjective feeling of being overwhelmed by tasks is likely to be a better predictor of stress than the number of roles or demands *per se* (summary in Pearson 2008). Yet, analyses of the effect of role overload have also yielded mixed results (summary in Coverman 1989) with some studies showing a detrimental effect (Coverman 1989; Crouter et al. 2001; Higgins et al. 2010; Glynn et al. 2009), others a favorable effect (summary in Coverman 1989), and some finding no effect at all (Hecht 2001). Coverman (1989) attributed these differences in findings to the inconsistent way role overload has been conceptualized and measured across studies.

Number of roles and well-being in later life

Until relatively recently, later life was generally characterized by role loss (often irreversible) and role vagueness (Adelmann 1994; Hong & Seltzer 1995). This was in accordance with the disengagement theory, which posited "that the gradual withdrawal from social interactions and activities is an inevitable accompaniment of old age, which eases the transition to death, thereby with minimal disruption to society when death occurs" (Bowling 2008: 293). However, improvements in longevity and health (Bengtson 2001) have changed this outlook (Bowling 2008). Nowadays, older people are more likely to combine more roles – for example, due to becoming grandparents while still fully engaged in paid labor and other personal endeavors (Ochiltree 2006; Reitzes & Mutran 2004), or as a consequence of active aging in retirement (Avramov & Mašková 2003; Uhlenberg 2005). More roles are also retained into higher ages (Adelmann 1994). Despite this, the link between the number of roles and well-being in later life remains largely under-researched (Adelmann 1994; Glaser et al. 2005). The concept of active aging operates upon the assumption that the combination of and partaking in multiple activities including paid work, volunteering, and active leisure enhance personal autonomy, health, and general quality of life and life satisfaction (Avramov & Mašková 2003; Uhlenberg 2005). Moreover, the elderly might enjoy the feeling of being busy, useful, or needed, especially faced with some of the common negative old-age stereotypes (e.g. isolation, dependency; Dionigi 2015). Some authors also mention that role underload (i.e. having too few roles), as well as role overload, might have a detrimental impact on well-being (summary in Shultz et al. 2010). On the contrary, multiple roles (and the resulting role conflict and overload) might be felt as more strenuous in older age – for example, as personal resources such as health or mobility diminish, or as work, family or caregiver roles interfere with hobbies and other preferred activities.[2] Existing evidence, despite its limitations, so far points to a positive association between number of roles and well-being in older age (Adelmann 1994; Hong & Seltzer 1995).

In the Czech Republic, systematic research into the number and types of roles and activities in later life is mostly missing, but data that can be drawn from existing sources seem to indicate that later life is generally not characterized by role withdrawal. Paid employment is usually pursued until the statutory age of retirement by both men and women (e.g. 75% of retirees in the 2011 wave of the *Survey of Health, Ageing, and Retirement in Europe* [SHARE] stated that they retired because they became eligible for a state pension); but about 37% of 60+ respondents in the *Life in Old Age* survey (2002) reported that they continued working even after reaching the statutory age limit, and 15% of respondents in the same survey described themselves as "working pensioners." In respect to family, at least some roles – especially those of spouse and parent – are, by their nature, retained into high age, while others, such as the role of grandparent, are added to the role set. According to the 2011 population census, only 4% of Czechs aged 50+ have never married and only 5% of women in the same age group have never had children (United Nations 2017). Increasing longevity also means the prolonged co-existence of several generations (Bengtson 2001). For example, among 50+ respondents in SHARE (2013), 20% had at least one parent still alive, more than 80% had at least one grandchild, and 23% had at least one great-grandchild.

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[2] For example, in her study among Czech active aging women, Hasmanová Marhánková (2013) found that many grandmothers – while frequently engaged with their grandchildren – refused to make grandparenting superior to other activities.

Moreover, these family roles often relate to care provision: in the same survey, more than 60% of persons who had at least one parent still alive and who reported that they had provided help in the past year helped their parents or in-laws; and about half of all grandparents looked after their grandchildren. Where leisure is concerned, older Czechs seem to be mostly drawn to passive activities: for example in 2011, 80% of SHARE respondents had read magazines and books in the past year, and 56% had done word or number games, while only 9% had attended education or training courses. However, 50+ year-olds in the *European Social Survey* (2014) spent on average 2.4 days a week exercising for 30 minutes or longer (compared to 2.9 days in the 15–49 age group). Moreover, about 40% of 50+ respondents in the *European Values Study* (2008) belonged to at least one volunteer organization and about 25% of persons did unpaid work for such organizations (cf. Kafková 2012).

In the following analysis of 50- to 70-year-olds in the Czech Republic, I will address some of the existing gaps in our knowledge about social roles in later life by analyzing the relationship between multiple roles and well-being. I will try to improve upon the shortcomings of existing research by using a number of roles that exceed the usual count of three by ten, that is, 13 roles in total. In the second step, I will try to assess the extent to which this association can be – at least partially – explained by other role-related factors, such as role overload, the particular types of roles one occupies, and the strain felt within one's role set. In addition, I will assess whether the link between multiple roles and well-being differs by age. I will also briefly focus on the "active ager" role, analyzing whether active agers are actually burdened by multiple roles or role overload. In the analysis, two main dependent variables will be used: stress measured on an 11-point scale, and overall well-being assessed using an abbreviated version of the *Philadelphia Geriatric Center Morale Scale* (PGCM), which was devised by Lawton in the early 1970s (Hastrup et al. 1986). If multiple role occupancy is primarily associated with strain, we should see lower levels of well-being and higher levels of stress among persons occupying multiple roles. On the contrary, if multiple roles enhance well-being, then the situation should be reversed. It should be noted that as it stands, the analysis is based on the assumption that the number of roles affects well-being, rather than vice versa. However, the results presented here should be viewed with caution as they are based on cross-sectional data and therefore no inference about causality in the relationship can be made. This limitation will be discussed in the final part of the article.

Data, Variables, Methods

To analyze the relationship between number of roles and well-being, I will make use of data from the *Life Roles* survey conducted in the Czech Republic in September 2014 among persons aged 50 to 70. The general aim of this survey was to collect data on older persons' activities, retirement, involvement with children and grandchildren, care provision, and social roles. This makes it highly suitable for the analysis, especially as it contains a section focused on the number, type, and evaluation of roles occupied. The survey was conducted using the computer-assisted personal interviewing (CAPI) method, with interviews lasting 43 minutes in average. The sample was created using quota sampling: In the first step, information from the 2011 census provided by the *Czech Statistical Office* was used to identify the socio-demographic structure of the Czech population aged 50 to 70 with respect to gender, age, education, NUTS 3 region, and size of place of residence. A sample of at least N = 700 observations was then designed to match this structure, and cases were assigned to individual interviewers. In total, information was collected from N = 730 respondents, and the final sample was representative of the population in question with respect to its selected characteristics[3] (Focus 2014). For the purposes of this analysis, I dropped all observations with missing values for one or more of the dependent or independent variables (N = 27 obs.). This then yielded a sample size of N = 703 observations.

The main independent variable was the number of roles. Respondents were given a list of roles and asked to state for each individual role whether or not they occupied it. There were fourteen roles in total including such items as spouse, grandparent, worker, friend, patient, and caregiver. The variable *number of roles* was created by adding up "yes" responses across roles and ranged from a minimum of 1 to the maximum of 13 roles (i.e. no respondent occupied all 14 roles). As already mentioned, stress and overall well-being were the two dependent variables. *Stress* was a continuous

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[3] The response rate was not reported by the agency responsible for the data collection, as it was stated that it did not affect the structure of the sample.

variable created using the incidence and intensity of stress reported by respondents as experienced in relation to their daily activities. It ranged from 0 to 10 where (1) represents stress of the lowest intensity while (10) represents the stress of the highest intensity. Zero then applies to persons who claimed to experience no stress at all. *Well-being* was measured using the sum of three items adapted from the original PGCM scale. These items assessed current feelings of verve (pep), usefulness, and happiness in comparison with an earlier point in time.[4] The variable ranged from 3 to 9 with (3) as the lowest and (9) as the highest level of overall well-being.

As controls, I included several elementary demographic variables: *gender* was a dichotomous variable coded (1) for female and (0) for male. *Age* was used in a categorized form with four categories: (1) 50–54, (2) 55–59, (3) 60–64, and (4) 65–70. *Education* had four categories that reflect the Czech system of education: (1) elementary, (2) lower secondary, vocational, (3) upper secondary, and (4) tertiary. *Health* was measured on a 10-point scale where (1) means "no health issues" and (10) "serious health issues." I did not include a measure of economic activity due to its collinearity with the "worker" role. In addition, to see whether the association between independent and dependent variables can be explained by other role-related factors, I included the following variables: role type, role overload, and role evaluation. *Role type* was represented by a series of dummy variables simply capturing whether a person did or did not occupy a particular role. From the initial list of fourteen, I chose eight (originally ten) roles: (1) spouse, (2) parent, (3) grandparent, (4) worker, (5) friend, (6) patient, and (7) caregiver. The roles of volunteer, person learning new things, and person pursuing hobbies comprised one category: (8) active ager. I defined as active agers those who reported occupying at least one of these three roles. *Role overload* was an index created as the sum of responses to five items[5] adapted for the questionnaire from Reilly's (1982) original

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[4] "Compared to last year, how much pep do you have?"; "As you get older, do you feel you are useful…?"; "How happy are you nowadays compared to when you were younger?" (*less—same—more*)

[5] (1) "I seem to have to overextend myself in order to be able to finish everything I have to do," (2) "I seem to have more commitments to fulfil than other people of my age," (3) "I just can't find the energy in me to do all the things expected of me," (4) "I need more hours in the day to do all the things which are expected of me," (5) "I am so busy that it results in conflicts with people around me."

13-item battery; it ranged from 5 to 25 where (5) is the lowest and (25) is the highest perceived overload. Lastly, respondents were asked to *evaluate* their roles and state which one (if any) caused them concern, was the most time-consuming, and was difficult to perform. For simplification, I created three dummy variables capturing simply whether or not respondents considered one of their roles to be particularly time-consuming, concerning, or difficult (1 = yes, 0 = no).

The association between number of roles, stress, and well-being was analyzed using OLS regression. In both instances, I estimated twelve models. They are described in Tables 1 (stress) and 2 (overall well-being) together with relevant statistics and results of the Wald test. The first model (M1, M7) only includes the number of roles; the second model (M2, M8) adds the elementary controls of gender, age, education, and heath. The third model (M3, M9) tests for an effect of role type by adding eight selected roles. The fourth model (M4, M10) further includes role overload. A series of follow-up models was used to see whether the relation between number of roles and stress (M5A) and well-being (M11A), or role overload and stress (M5B) and well-being (M11B) differed between age groups, and also whether partaking in active aging had differing effects across age groups (M5C, M11C). Models M5D/M11D and M5E/M11E then add the interaction between the active ager role and number of roles (D) and role overload (E) to see whether this group is actually burdened by multiple roles/role overload in respect to stress and well-being. The last set of models elaborates upon the fourth model (M4, M10) by controlling for strain experienced within the role set with respect to the dimensions of time (a role in the role set is perceived as time-consuming; M6A, M12A), concern (a role in the role set is a source of concern; M6B, M12B), and performance (a role in the role set is difficult to perform, M6C, M12C). The results from selected models are presented in Tables 3 and 4.

Results

Table 5 summarizes the descriptive statistics. We see that 53% of respondents were female and the average age was 60 years. Most respondents attained lower secondary/vocational education (41%), while 29% of respondents attained higher secondary education, and 13% of respondents were university educated. In respect to health, respondents were neither

Table 1. Goodness-of-fit statistics of estimated OLS regression models of the association between number of roles and stress

	F	df.	R^2	*p*	BIC	Wald test	
						F	*p*
Model 1: number of roles	38.86	1	0.053	<0.00005	3123.55		
Model 2: M1+gender, age, education, health	12.21	9	0.137	<0.00005	3110.42	9.65	<0.001
Model 3: M2+role types	7.81	17	0.162	<0.00005	3141.87	2.60	<0.01
Model 4: M3+role overload	12.94	18	0.254	<0.00005	3066.92	84.09	<0.001
Model 5A: M4+age*number of roles	11.11	21	0.255	<0.00005	3085.53	0.34	0.796
Model 5B: M4+age*role overload	11.22	21	0.257	<0.00005	3083.70	0.93	0.424
Model 5C: M4+age*active aging	11.18	21	0.256	<0.00005	3084.30	0.74	0.528
Model 5D: M4+active ager*number of roles	12.52	19	0.258	<0.00005	3069.40	3.97	<0.05
Model 5E: M4+active ager*role overload	12.68	19	0.261	<0.00005	3067.04	6.28	<0.05
Model 6A: M4+role evaluation: time-consuming	12.29	19	0.255	<0.00005	3072.68	0.78	0.379
Model 6B: M4+role evaluation: concerning	12.55	19	0.259	<0.00005	3068.98	4.38	<0.05
Model 6C: M4+ role evaluation: difficult	12.79	19	0.262	<0.00005	3065.52	7.77	<0.01

Czech Republic, *N* = 703 observations.

Table 2. Goodness-of-fit statistics of estimated OLS regression models of the association between number of roles and overall well-being

	F	df.	R^2	*p*	BIC	Wald test	
						F	*p*
Model 7: number of roles	52.33	1	0.068	<0.00005	2333.67		
Model 8: M7+gender, age, education, health	20.69	9	0.212	<0.00005	2269.39	15.65	<0.001
Model 9: M8+role types	12.36	17	0.235	<0.00005	2301.07	2.57	<0.01
Model 10: M9+role overload	11.87	18	0.238	<0.00005	2304.63	2.92	0.088
Model 11A: M10+age*number of roles	10.22	21	0.240	<0.00005	2322.79	0.49	0.692
Model 11B: M10+age*role overload	10.20	21	0.239	<0.00005	2323.13	0.38	0.771
Model 11C: M10+age*-active aging	10.15	21	0.238	<0.00005	2324.00	0.10	0.962
Model 11D: M10+active ager*number of roles	11.24	19	0.238	<0.00005	2311.05	0.13	0.716
Model 11E: M10+ active ager*role overload	11.34	19	0.240	<0.00005	2309.54	1.60	0.207
Model 12A: M10+role evaluation: time-consuming	11.45	19	0.242	<0.00005	2307.96	3.14	0.077
Model 12B: M10+role evaluation: concerning	11.28	19	0.239	<0.00005	2310.41	0.75	0.387
Model 12C: M10+role evaluation: difficult	11.35	19	0.240	<0.00005	2309.37	1.76	0.185

Czech Republic, *N* = 703 observations.

Table 3. Estimated coefficients from selected OLS regression models of the association between number of roles and stress

	M1	M2	M3	M4	M5D	M5E	M6C
Number of roles	0.234***	0.198***	0.159*	0.142*	0.284**	0.144*	0.122†
Female		0.094	0.055	0.106	0.093	0.093	0.114
Age (50–54 is ref. category)							
55–59		-0.697***	-0.713**	-0.582**	-0.581**	-0.587**	-0.589**
60–64		-0.831***	-0.602*	-0.309	-0.293	-0.303	-0.343
65–70		-1.437***	-1.046**	-0.737*	-0.739*	-0.739*	-0.763**
Education (primary is ref. category)							
Lower secondary		0.185	0.171	0.096	0.071	0.075	0.102
Upper secondary		0.395	0.368	0.215	0.196	0.188	0.203
Tertiary		0.356	0.244	0.121	0.127	0.116	0.133
Health		0.254***	0.268***	0.188***	0.193***	0.194***	0.176***
Role type							
Spouse			-0.462*	-0.486*	-0.534*	-0.501*	-0.438*
Parent			0.383	0.527†	0.459	0.524†	0.523†
Grandparent			-0.089	-0.309	-0.325	-0.326	-0.245
Worker			0.683**	0.400†	0.376†	0.441*	0.392†
Friend			0.375	0.293	0.253	0.263	0.268
Patient			0.045	0.029	0.019	0.044	-0.010
Caregiver			0.382†	0.123	0.127	0.130	0.124
Active ager			-0.014	-0.005	1.089†	1.396*	0.001
Role overload				0.179***	0.178***	0.247***	0.163***
Interactions							
Active*number of roles					-0.179*		
Active* overload						-0.099*	
Role evaluation							
Difficult							0.460**
Intercept	2.365***	1.751***	1.074*	-0.754	-1.391*	-1.708**	-0.555

***$p < 0.001$; **$p < 0.01$; *$p < 0.05$; †$p < 0.1$.

Czech Republic, $N = 703$ observations.

Table 4. Estimated coefficients from selected OLS regression models of the association between number of roles and overall well-being

	M7	M8	M9	M10	M12A
Number of roles	0.155**	0.115**	0.094*	0.096*	0.098*
Female		0.034	0.086	0.080	0.073
Age (50–54 is ref. category)					
55–59		0.022	0.036	0.021	0.020
60–64		-0.014	0.026	-0.006	-0.019
65–70		-0.151	-0.127	-0.160	-0.158
Education (primary is ref. category)					
Lower secondary		0.156	0.125	0.133	0.146
Upper secondary		0.110	0.071	0.088	0.094
Tertiary		0.292†	0.258	0.272	0.271
Health		-0.226**	-0.194**	-0.185**	-0.183**
Role type					
Spouse			0.145	0.147	0.111
Parent			-0.249	-0.265	-0.266
Grandparent			0.236*	0.260*	0.242*
Worker			0.116	0.147	0.114
Friend			-0.230	-0.221	-0.219
Patient			-0.175	-0.173	-0.182
Caregiver			-0.129	-0.101	-0.109
Active ager			0.283*	0.282*	0.257*
Role overload				-0.019†	-0.022†
Role evaluation					
Time-consuming					0.311†
Intercept	4.570**	5.896**	5.905**	6.103**	5.896**

$^{**}p < 0.001$; $^{*}p < 0.05$; $^{\dagger}p < 0.1$.

Czech Republic, $N = 703$ observations.

Table 5. Descriptive statistics

Gender (% of women)	53	Role (% occupies)	
Age (average)	59.5	Spouse	69
Age (categorized, %)		Parent	89
50–54	24	Grandparent	61
55–59	26	Worker	55
60–64	27	Friend	90
65–70	23	Patient	41
Education		Caregiver	25
Primary	17	Active ager	66
Lower secondary	41	Age group 50–54	
Upper secondary	29	Spouse	75
Tertiary	13	Parent	87
Health (average)	5.2	Grandparent	37
Number of roles (average)	7.1	Worker	87
Number of roles by age (average)		Friend	88
50–54	7.7	Patient	28
55–59	7.6	Caregiver	25
60–64	6.9	Active ager	76
65–70	6.2	Age group 65–70	
Role overload (average)	14.3	Spouse	56
Stress (average)	4.0	Parent	89
Stress by age (average)		Grandparent	85
50–54	4.8	Worker	11
55–59	4.1	Friend	87
60–64	3.9	Patient	58
65–70	3.3	Caregiver	20
Well-being (average)	5.7	Active ager	58
Any role is (% yes)			
Time-consuming	92		
Concerning	80		
Difficult to perform	44		

Life Roles survey, Czech Republic 2014, $N = 703$ obs.

perfectly healthy nor severely ill; the average score was 5.2. On average, respondents occupied 7 roles, and while there were differences between age groups, these were not particularly stark: as we can see, the youngest persons in the sample (aged 50–54) occupied an average of about 7.7 roles, while the oldest respondents (aged 65–70) reported an average of 6.2 roles. This relatively small (but statistically significant) difference of 1.5 roles likely reflects the narrow age composition of the sample. However, it might also imply "trade-offs" between roles with aging, that is, while some roles (such as worker or offspring) are lost, others (such as grandparent or patient) are gained, which slows the pace at which role sets diminish over time. The average role overload score was 14.3 points, average stress was 4.0 (and declined across age groups), and the average overall well-being score was 5.7. The correlation between role overload and number of roles was statistically significant and positive, but weak (0.22 on $p < 0.001$), as was the correlation between number of roles and stress (0.29 on $p < 0.001$). However, there was a moderately strong positive correlation between role overload and stress (0.42 on $p < 0.001$; correlations not shown).

Moving to the second part of Table 5, *parent* and *friend* were the prime roles (with about 90% of respondents occupying them), followed by spouse (69%), active ager (66%), grandparent (61%), and worker (55%). In the youngest age group (50–54), the *parental*, *friend*, and *worker* roles were the most frequently occupied (by about 88% of respondents), while in the oldest group (65–70), *parent*, *friend*, and *grandparent* were the most frequent. At least one of the "active aging" roles was reported by 76% of 50- to 54-year-olds and 58% of the 65+ year-olds. The bottom part of Table 5 summarizes role strain: almost all respondents had a role in their role set that they deemed particularly time-consuming, and 80% of them occupied a role that was a source of concern. On the contrary, 44% of respondents had a role that they found difficult to perform, while 56% declared themselves to have no such role.

Number of roles and stress

Table 3 summarizes the results from selected OLS regression models of the association between the number of roles and stress. Model 1 shows that these two variables were positively related and that the estimated coefficient was statistically significant (0.234 on $p < 0.001$), indicating that stress levels were higher among persons occupying multiple roles. Note, however, that in itself the number of roles accounted for only about 5% of the variance of the dependent variable. After the addition of elementary controls into Model 2, the estimated coefficient for the number of roles shrank but remained statistically significant (on $p < 0.001$). Inspecting Model 2, we can see that stress was not affected by gender or education but declined across age groups and increased with deteriorating health. Moving to Model 3, adding role types further weakened the observed association (the coefficient changed from 0.198 in M2 to 0.159 in M3) but it remained statistically significant. In respect to individual roles, spouses were on average less stressed by their daily activities than persons who did not have a (marital) partner. On the contrary, everything else being equal, workers reported higher levels of stress on average when compared to their counterparts who did not work. Caregivers were also somewhat more stressed than persons who did not provide care, but the effect bordered on statistical significance ($p < 0.1$). Active agers were no different with regard to their stress levels than those who did not partake in volunteering, learning, or hobbies. The results from Model 4 show that role overload could not fully account for the positive association between number of roles and stress, as there was some change to the estimated regression coefficient but no change to its statistical significance. However, the perceived overload seemed to account for some of the effect of age. The effect of overload itself was positive and statistically significant: with each unit increase in overload, stress increased by 0.179 points.

Models 5A to 5C do not lend support to the expectation that the relationship between number of roles and stress (M5A), role overload and stress (M5B), and active aging and stress (M5C) would differ across age groups. On the contrary, interactions between active aging and number of roles (M5D) and role overload (M5E) were statistically significant. The results are summarized in Table 3. Interestingly, controlling for these interactions changed the coefficient for the active ager role from negligibly negative and non-significant (in Models 3 and 4) to positive and statistically significant (on $p < 0.1$ and $p < 0.05$ in models M5D and M5E, respectively). This means that active agers were, on average, more stressed than their non-active counterparts (scoring more than 1 point higher on the stress scale). However, the observed interactions were negative in both models, implying that each additional role – and each unit increase in overload – actually decreased stress in active agers. The last series of models test for the effect of role strain. The Wald test results support the inclusion of "concern" and "difficulty." Overall, persons who saw one of their roles as a source of (non-time-based) strain scored higher on stress than their counterparts who did not. Moreover, the inclusion of these "strain" variables brought to both Models 6B and 6C a change in the statistical significance of the coefficient for number of roles from the $p < 0.05$ level to $p < 0.1$. Table 3 shows the results from Model 6C as the effect of "difficulty" was very slightly more pronounced than the effect of concern.

Number of roles and overall well-being

The same set of models was re-estimated with the PGCM index as the dependent variable. Model comparisons are shown in Table 2; results from selected models are shown in Table 4. Interestingly, we see that number of roles and overall well-being were also positively related, meaning that persons occupying multiple roles – compared to their counterparts occupying few roles – were more stressed but at the same time better off in respect to well-being. The estimated regression coefficient for number of roles did shrink when controlling for demographic characteristics in Model 8, but there was no change in its statistical significance ($p < 0.001$). Among these controls, only health exerted a statistically significant negative effect (meaning there was lower well-being among persons in poorer health). The addition of role types into Model 9 further weakened the coefficient for number of roles (from 0.115 in M8 to 0.094 to M9) but again it remained positive and statistically significant. In respect to individual roles, everything else being equal, grandparents reported higher well-being on average than persons who did not identify themselves as grandparents. Moreover, active agers also scored higher on well-being than their non-active counterparts. The effect of other roles was not statistically different from zero. Adding role overload into Model 10 did not change the effect of number of roles and, based on the Wald test, was only a marginally significant improvement on Model 9 (indeed, the effect of overload on well-being was minute and significant at $p < 0.1$). Again, interactions between age group and number of roles, role overload, and active aging did not improve Model 10, but neither did the interaction between active aging and number of roles (M11D) and role overload (M11E), meaning that among active agers – unlike stress – there was no difference in overall well-being by number of roles occupied or the feeling of overload. The strain felt within one's role set did not constitute a particular improvement to Model 10, although occupancy of a time-consuming role (M12A) had a marginally significant ($p < 0.1$) positive effect: those who claimed to occupy such a role were better off in respect to their well-being than those who reported having no such role, everything else being equal.

Discussion

In the Czech context, I found that the number of roles was positively related to both stress and overall well-being as measured by the PGCM scale. This means that among 50- to 70-year-old Czechs, those with a higher number of roles had on average higher levels of stress but also higher levels of well-being than those with fewer roles, even when controlling for a number of other variables. As such, these findings are not fully in line with either of the above discussed hypotheses: while the strain hypothesis is supported in respect to stress, the enhancement hypothesis is supported in respect to well-being. This is curious as it would indicate that stress and well-being are not strongly linked and imply that partaking in a number of diverse activities – while simultaneously stressful – makes individuals feel useful, full of verve, and, by extension, happy, which are the items that comprise the measure of well-being used here (cf. Sieber 1974).[6] While such an assertion seems feasible, the explanation might in fact lie in the nature of the dependent variables used in the analysis – especially stress specified as "experienced in relation to daily activities" might have been both too vague and too narrow to capture any effect of multiple roles that would transcend the short-lived tensions experienced in everyday life. This means that if measured differently, the results might have been less ambiguous. Anyhow, it might be useful to use both "positive" and "negative" measures of well-being when testing the strain and enhancement hypotheses in the future.

The positive association between number of roles and stress could not be fully explained by the types of roles a person occupied, role overload,

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[6] Indeed, the correlation between stress and the PGCM index was extremely weak (-0.111, $p < 0.01$) in this particular dataset.

or the strain felt within one's role set, although all three had some effect on its strength. Overall, some of the association was attributable to occupying a worker role (as seen, workers were on average more stressed than persons who did not work), experiencing role overload, and experiencing one role as particularly concerning or difficult to perform, with the effect of strain likely the decisive one (as seen, controlling for strain not only weakened the association between number of roles and stress but also changed the statistical significance of the coefficient for number of roles toward $p < 0.1$). Similarly, the observed relationship between number of roles and overall well-being could not be fully explained by other role-related factors, but seemed to be partially attributable to the types of roles a person occupied, especially if these were the roles of grandparent and active ager, that is, roles that could be understood as enjoyable (in fact, 40% of respondents in the *Life Roles* survey stated that the role of grandparent made them the happiest, while 13% of respondents said it was their active ager role that made them the most happy[7]). On the contrary, the effect of role overload on this association was negligible (as indeed was its effect on well-being) and so was the effect of time-based strain. Interestingly, persons who reported having a role that they deemed particularly time-consuming had higher overall well-being than those who declared having no such role. Being busy, it would seem, elicits personal benefit rather than strain. All in all, these results indicate that the relationship between multiple roles and well-being is mostly irreducible to role type, role overload, and role strain (at least among Czechs aged 50 to 70 years).

In respect to aging, I was not able to document that the association between number of roles and well-being differed across age groups. This is also true for role overload; while overload clearly accounted for some of the effect of age on stress[8] (as seen in Model 4 in Table 3), its effect was not modified by age. On the contrary, the relationship between number of roles and stress (and indeed role overload and stress) varied between

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[7] Followed by 12% citing their parental role, 10% citing their spousal role, and 8% citing their friend role.

[8] In the sense that older persons were not as stressed as they experienced lower levels of overload. This is supported on the descriptive level – while 50- to 54-year-olds reported an average overload of 15.4, 65+ year-olds reported an average overload of 13.3.

those who did and did not partake in active aging. We saw that when controlling for interactions between active aging and number of roles and between active aging and role overload, active agers were actually more stressed than their counterparts who did not pursue volunteering, learning, or hobbies, yet were less so with each additional role they occupied. Therefore, active agers were likely not burdened by multiple roles (either by number or by overload); the opposite was the case. We can speculate that active aging mitigates stress only where it entails/is accompanied by multiple activities rather than only a handful ("keeping busy"). However, the advantage might be down to occupying other key roles – for example, being involved in paid employment, thus generating financial resources needed to promote participation in enjoyable endeavors. Alternatively (as the direction of the relationship is unclear), lower stress levels might allow active agers to pursue multiple roles. Interestingly, this was not observed for overall well-being. While active agers scored higher on well-being, there was no benefit or burden associated with multiple role occupancy.

Several limitations of the analysis should be discussed. The definition of an "active ager" was far from exhaustive, as it was reduced to volunteering, pursuing hobbies, and learning new things. This was a practical solution; in theory, most roles occupied in older age might be considered to play a part in active aging, yet I chose to test separately for the effect of as many roles as possible. It follows that when talking about active agers, the analysis refers to those partaking in at least one out of three possible activities that have close ties to leisure. It is also true that the analysis largely omitted the gender aspect despite the fact that some previous findings pointed out that women rather than men tend to be more overwhelmed and overloaded by tasks (Simon 1995). We saw that gender had no effect on well-being, but attention was not given to the interaction between number of roles and gender, as this was beyond the scope of this article. Also, the age composition of the sample did not allow any investigation into the link between roles and well-being among persons above the age of 70.

Most importantly, however, the cross-sectional nature of the data did not allow the direction of the relationship between number of roles and well-being to be inferred. While both the enhancement and strain hypotheses expect that multiple roles have an effect on well-being, well-being might in fact have an impact on the number of roles occupied: while persons scoring high on well-being might be more inclined to engage in multiple roles, those low on well-being might avoid role accumulation[9] (cf. Adelmann 1994; Ahrens & Ryff 2006; Hong & Seltzer 1995; Moen et al. 1992). However, existing longitudinal evidence seems to lend support to the expectation that well-being is affected by the number of roles. For example, on the basis of their analysis of number of roles and depression among older Wisconsin mothers caring for a handicapped child, Hong and Seltzer (1995) concluded that "multiple roles preceded depression in casual ordering" (p. 939), as the change in the number of roles affected depression even with the initial depression level controlled for. A similar conclusion in respect to causality was reached by Nordenmark (2004), who analyzed number of roles and well-being in the general population of Sweden. Moreover, in an overview of analyses focused on the link between activity and well-being in later life, Adams et al. (2011) summarized that in longitudinal studies, activity often predicted well-being rather than vice versa. This being said, the accumulation of roles and the level of well-being may both be affected by other factors (such as specific personality traits) that were not accounted for by the models presented here. The results should therefore be taken with caution. Future analyses should improve upon at least some of these shortcomings, as well as introduce different measures of well-being and focus on cross-country comparison, if possible using large-scale harmonized international datasets, preferably with a longitudinal element in order to see whether multiple role occupancy in fact enhances or harms well-being in later life.

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[9] However, in the present analysis this cannot be said for stress, as those occupying multiple roles were more stressed – unless particularly stressed individuals seek to alleviate stress by engaging in additional roles.

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Virpi Timonen (2016). *Beyond Successful and Active Ageing: A Theory of Model Ageing*. Bristol, UK: Policy Press, 119 pp. ISBN 978 1 4473 3017 2 (hardback)

*REVIEWED by DORA TADIC**

The book *Beyond Successful and Active Ageing: A Theory of Model Ageing* by Virpi Timonen provides a new approach to successful and active ageing. In it, the author offers both a critique and constructive advice on these concepts, aiming to set grounds for a new theory of model ageing. This review will summarise the main points Timonen makes in the five chapters of the book, and will also situate the book around existing research on successful and active ageing, showing the main strengths of the book and offering some critique.

The first chapter offers a motive behind developing a new theory. Timonen's main argument is based on the paradoxes that exist in ageing societies and that construct older people in ambivalent terms. Older people are expected to be active and in control of their lives, but are at the same time perceived as individuals who lack agency (Timonen 2016). Furthermore, researchers, policy makers and marketing experts often treat them as a homogenous group, while the differences based on their gender, sexual orientation, social class and ethnicity are mostly overlooked. This creates a homogenous image of the older population and the belief that there is a single ageing model that can and should be applied to everyone.

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These and other paradoxes, "the puzzle of gender and social class blindness," "the puzzle of assuming strong agency in welfare production" and "the paradox of turning the problem into the solution" (Timonen 2016: 2–3), lead Timonen to offer a new theory of model ageing.

The second chapter explores the concept of successful ageing. In it, Timonen argues that one of the main critiques of successful ageing is the lack of an agreed definition of the concept. Even though a number of researchers tried to define successful ageing (e.g. Havighurst 1961; Peterson & Martin 2015; Rowe & Kahn 1997), it is difficult to agree on a single definition because of the different perception of the concept of successful ageing between the researchers and their participants. Timonen further argues that successful ageing has become "a commodity for sale" (Timonen 2016: 23). This is concurrent with Katz and Marshall (2003), who argue that products aimed at the older population, such as Viagra, and various medical and rejuvenating treatments are often tailored to suit business and medical entrepreneurs who are not only accommodating but also actively creating a new, and very large, consumer group (Loe 2004).

In the third chapter, Timonen argues that active ageing is a policy term, used mainly as a response to population ageing in Europe. Even though active ageing takes a more life–course oriented approach than successful ageing, it is still defined in a framework of economic and productivist perspective, making it a base for global and European policy developments. One of the examples is policies on independent living, which imply all older people are capable of living on their own without any major problems. The other is aimed towards policies on economic contributions, such as prolonged working life and prevention of age discrimination. Both examples show a lack of a person-centred approach, an issue often seen in geriatric medicine as well (e.g. in the work by Bentrott & Margrett 2011). The individual needs of older people, therefore, lack recognition at policy level, resulting in active ageing policies that cover only a number of "model" citizens who fit the model of successful ageing.

Timonen's division of older people into "model" and "anti-model" citizens serves to show how difficult it is to model ageing. A "model" citizen is a person who lives by the successful and active ageing concepts, and the "anti-model" citizen is a person who deviates from those concepts for whatever reason. As the context in which people live is relevant for their behaviour as "model" or "anti-model" citizens, Timonen wonders why some people behave as "model" citizens in an environment that does not encourage successful and active ageing, and why there are "anti-model" citizens in countries that reward it. Understanding this behaviour is the key to developing a new theory of model ageing, because it can guide new research to focus on various social determinants of successful and active ageing, such as the life course, which Hendricks (2012) proposes is one of the key aspects in studying ageing, and the agency older people actually have over their own ageing process (Timonen 2016).

Timonen's model ageing theory is of course not the first one to explore the downsides of the successful and active ageing models, and to propose a different approach to ageing. For example, the model of optimal ageing discussed by Aldwin and Gilmer (2004) allows for different ways of ageing well, depending on the person's resources, health status and the choices they make. Similarly, the model of harmonious ageing, by Liang and Luo (2012), is based on the Yin–Yang philosophy and understands ageing as a balance based on differences rather than on uniformity, which links to Timonen's critique of the homogeneity of the successful ageing model. Both of these theories are based on the downsides of successful ageing, trying to include the aspects of ageing that the successful ageing model has neglected. However, while successful and active ageing are models which have policy and research implications, optimal and harmonious ageing are still only talked about on a theoretical level, perhaps lacking institutionalised support that would help transform them into new model ageing policies.

As difficult it might be to propose a new theory of ageing, Timonen argues that it is necessary to at least try to do it. In an attempt to move towards a new model, she proposes 10 postulates that combine "policy ideals, commercial depiction *and* academic conceptualisations" (Timonen 2016: 89; emphasis in original) of model ageing. The ones most relevant for the discussion argue that there are actors who have an interest in controlling and classifying population ageing for capitalist gains, that model ageing expects that people with least resources adapt and change the most and that, in the future, there will be "increasing exhortations on older adults to adapt and change their behaviours" (Timonen 2016: 94), creating more negative consequences for the disadvantaged.

In conclusion, Timonen does not solely argue for an immediate development of a new theory of model ageing. She proposes looking beyond the concepts of successful and active ageing, and focusing on "what really matters: how to help those who struggle most to reach good outcomes in old age" (Timonen 2016: 99). Timonen's arguments make this book an excellent addition to the field of ageing studies, especially to the area exploring successful and active ageing, and their alternatives. It is also a good starting point for developing a new way of thinking about the older population, approaching them as individuals rather than as a new target group for a plethora of anti-ageing products.

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Jaco Hoffman and Katrien Pype (eds.) (2016). *Ageing in Sub-Saharan Africa. Spaces and Practices of Care.* Bristol: Policy Press, 248 pp. ISBN 978 1 4473 2525 3 (hardback)

*Reviewed by Monika Wilińska**

Ageing studies in general, and gerontology in particular, have been rightly criticised for reliance on and emphasis of Western conceptions and imaginaries of ageing and old age. This is changing and contributions such as the book edited by Jaco Hoffman and Katrien Pype are at the forefront of this transformation. Included in the *Ageing in a Global Context* Polity Press series, the book raises to the challenge of advancing knowledge on global diversity and local complexities shaping the experience of ageing and old age worldwide. It offers an essential engagement with discourses, experiences and realities of care in old age in sub-Saharan Africa (SSA) to foreground new ways of thinking and conceptualising care in that region.

The focal point of this edited volume is old age care as a practiced, organised and emplaced social phenomenon that is deeply embedded in the sociopolitical and cultural context and embodied in the everyday lives of care receivers and care providers. With this, as editors emphasise in the *Introduction*, the book offers important insights into the realities of care practices and relationships in SSA that merit both research and policy attention. Furthermore, it attempts to develop a new vocabulary

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to conceptualise this phenomenon. In his *Afterword*, Andries Baart differentiates between six discourses of care based on the motives for providing as emergent from the stories narrated in the book. Ranging from tradition-based to market-oriented mechanisms, those discourses coexist in the region creating unique combinations in each setting examined.

What unites the book's various discourses of care in SSA is the underlying story of lack of political interest in issues regarding older women and men's health and welfare. The contributing authors identify this as a key challenge and dilemma awaiting old age care in SSA. This in turn results from presumed and unquestioned ideas regarding the primacy of family care to cater for the needs of older people. Sjaak van der Geest's case study of political discourses regarding care of older people in Ghana (Chapter 1), exemplifies that point very well. His critical reading emphasises the lack of political imagination and understanding of the changing socioeconomic reality that influences family structures and relationships as well as care practices. In a similar vein, Jaco Hoffman discusses the plethora of ways in which younger and older generations of South Africans approach the concept of family care (Chapter 7). Although those different generations speak about the same phenomenon, their motivations and understanding diverge, which may potentially lead to a disparity between care expectation and actual care practices. Above all else, Hoffman's chapter demonstrates that family care is not a concept to be taken for granted, especially in political discourses.

The contributing authors are far from approaching care of older people as a problem. On the contrary, thanks to deep and engaged research, they beautifully narrate complex stories and perspectives on care and ageing in SSA. One common perspective that emerges from the chapters is agency. Difficult sociopolitical and economic situations set the background for the whole book, but not a single chapter is affected by a victim perspective. Instead, the volume is a mesmerising collection of research stories built on prolonged engagement with the field, and it emanates with authentic voices of people who are actively involved in *doing care* regardless of their social status and health condition.

For example, Emily Freeman with her study of old age identities in rural Malawi adeptly introduces the reader to the immense amount of identity work that older women and men perform to adjust to changing social and corporeal realities (Chapter 5). Against the background of physical work as a social imperative, the interviewees who were unable to work creatively built new identities that allowed them to navigate through their lives. In doing so, they also attest to the importance of bodily experience in mitigating ageing and old age. Brigit Obrist writes about a similar phenomenon in her study of home care for older people that acquired physical disability (Chapter 4). The physical changes in the body were used to determine not only how care should be provided but also where and by whom. This is also reflected in Josien de Klerk's study of neglect in Tanzania (Chapter 6). This chapter demonstrates how changes in physical and mental conditions transform care and care relations, and simultaneously reveals the various vulnerabilities of care providers and care receivers who may neither be ready nor willing to deal with the new circumstances. Negotiation and fluidity become accurate descriptions of family care practices in that context.

Traditionally, family care in old age is about children providing for their older parents. However, elder-to-elder care – for example, caring for a spouse or sibling – is an increasingly recognised everyday practice of care in SSA. Chapter 3 is informative in this respect. Peter van Eeuwijk, in his study of elder-to-elder care in Tanzania, emphasises the adaptive aspect of care relations and practices that are affected by the changing socioeconomic context (Chapter 3). This points to a more collective response to older people's needs that is distributed among different family members if a need arises. Nevertheless, family care is not always available. Katrien Pype in her study of retirement homes in the Democratic Republic of Congo sheds light on the lives of older people *without value* – mainly older women with no children (Chapter 2). Her in-depth analysis leaves no doubt about the agential strength of residents who engage with the surrounding community, in order to create new relationships and – more importantly – to redeem their social status.

One of the greatest challenges of cross-cultural research on ageing is the development and practice of critical and reflexive approaches, not only towards sociocultural contexts but also with regard to conceptual and theoretical frames (Wilińska et al. 2017). The edited volume, written by Europe- and Africa-based researchers about ageing and care in SSA, raises to that challenge. It also makes an important step towards establishing a firm foundation for the highly sought-for family gerontology in Africa that with its interpretive, critical and global character would question common myths about family care and open a space for discussions emphasising heterogeneity and complexity (Aboderin & Hoffman 2016). The explorative character of the book introduces readers to some of the most important aspects of care in SSA. It does not exhaust them though, but it competently hints on the unexplored questions, encouraging further investigations.

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Anya Ahmed (2015). *Retiring to Spain. Women's Narratives of Nostalgia, Belonging and Community.* Bristol: Policy Press, 208 pp. ISBN 978 1 44731 330 4 (hardback)

*REVIEWED by ANNE LEONORA BLAAKILDE**

The market for books concerning the topic international retirement migration (IRM) or lifestyle migration is growing these years, and Anya Ahmed's work on retired, British women's narratives concerning their migration to Spain is a very interesting new study in this line. Ahmed is focusing on *community* and *belonging,* and what makes this book most interesting to read is the thorough theoretical context of the work, especially regarding the narrative inspiration in the analytical approach. This, in turn, also results in interesting interpretations of the different situations and positions represented by the 17 women interviewed.

Using plot theory and the analytical terms *quest* or *voyage and return*, Ahmed investigates and interprets the variety of motivations for migration, and different degrees of satisfaction with the new life abroad, related to a plethora of reasons. The study is in essence qualitative, because the narrative nostalgia of each interviewee forms a basis for analyses and interpretations. Ahmed shows that although the women encompass individual biographies, their migration also bifurcates into two typologies. The first type involves the ones who see their migration

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as a “quest” and, hence, are satisfied with their lives abroad. The other type represents the ones who did not find the life satisfaction they sought for, and hence whose stories are marked by “voyage and return.” With the term “nostalgia,” Ahmed emphasises that all migrations are led by a desire for community and belonging, and a desire to link time and space. This is achieved either through an attempt to live in a space similar to their past, representing what was experienced as lost in the United Kingdom; or in another spatial present, providing a positionality that is considered better than the one available in their homeland.

Ahmed herself puts it this way (p. 51): “I premise that women´s quest for belonging and community through retirement migration can be understood as both spanning and reconstituting boundaries in relation to place(s) and networks, shaped by their multiple and overlapping social locations or positionalities across space and time through nostalgia.”

In order for the retirement migration to be successful, Ahmed’s interviewees needed to be able to express a coherent experience of community and belonging in their new lives regarding several issues. Ahmed treats these issues in the book chapters, with focus on age, gender, class, ethnicity, (national) identity, sociability and images of the different spaces in their lives; the new living environment and to what degree this represents a better quality of life than the old one in the United Kingdom. The cultural impact of family relations is discussed in several chapters. Ambiguities are presented, especially those experienced by many female migrants regarding living at a distance from family members or even having taken the decision to part from their old parents, adult children or grandchildren. It becomes clear that family represents a challenging common cultural norm connected to women as caretakers and kin keepers. As the other chapters in the book, the ones about family relations and intergenerational solidarity are richly informed by relevant theories. Ahmed shows how the interviewed women reconcile and reconceptualise their personal “grandmother-narratives,” integrating norms about intimacy, love and caring in congruence with parallel norms of non-interference and individuality. At the same time, many of the personal grandmother-narratives are interpreted on their own terms, so variations are revealed.

This book is very inspiring and refreshing because of the rich theoretical input and the narrative approach, which is not common in much IRM literature (However, see Woube 2014). Another issue, which is not so often mentioned in many works on IRM, is ill health as a motivating cause for migration and its consequences for the migrant's further life in the new country – as well as for a possible return migration. In this book, this issue is also not touched upon as such – though it is mentioned explicitly that at least three of the women interviewed moved to Spain due to their husbands' ill health. I mention this because health is a very common motivation for migration for retirees, and it is an important factor for both quality of life and prospects of health services and care needs while living abroad or living transnational lives. Therefore, the topic of health needs to be taken into more serious consideration by host countries, home countries, health service providers, environmentalists, house constructors and by researchers. We once and again find this topic in our empirical material, however, most often it is not being proposed an issue of much attention.

Regarding literature of IRM and lifestyle migration, I will recommend reading this book, especially because of the inspiring linguistic and narrative analyses, drawing on relevant and new theories.

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