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Original Article

The Old and the Oldest-old: Do They Have Different Perspectives on Adjustment to Aging?☆

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SUMMARY

Background: Older adults experience varying challenges in old age. This study aims to explore the indicators of adjustment to aging (AtA) and to examine the potential explanatory mechanisms of a correlational model for AtA for the old and oldest-old adults.
Methods: This qualitative study comprised demographics and semistructured interviews. Complete information on 152 older adults aged between 75 years and 102 years (mean = 83.76 years; standard deviation = 6.458). Data was subjected to content analysis. The correlational model of indicators of AtA was analyzed using a multiple correspondence analysis.
Results: "Occupation and achievement" was the most mentioned indicator of AtA by the old participants (17.7%), whereas "existential meaning and spirituality" was the most verbalized indicator of AtA for the oldest-old participants (16.9%). AtA was explained by a three-factor model for each age group. For the old participants, the largest factor "occupational and social focus" accounted for 33.6% of total variance, whereas for the oldest-old participants, "spirituality and health focus" represented 33.5% of total variance.
Conclusion: The outcomes presented in this paper stressed the varied perspectives concerning AtA, contoured in two different models, and the need of considering these when designing and implementing programs in health care for the old and the oldest-old.

1. Introduction

Globally, the older population is growing at a rate of 2.6% per year, considerably faster than the population as a whole (1.2% annually). Currently, older people survive to even more advanced ages. The oldest-old (85+ years) constitute 7% of the world's 65 years-and-over population. Additionally, it is projected an increase of 151% between 2005 and 2030 for the oldest-old population and a 104% increase for the old population aged between 65 years and 85 years[1].

It is generally accepted that as a person ages, the experiences acquired over the life time, socioeconomic resources, relationships, and support systems may profoundly impact longevity and well-being[2]. Furthermore, as older adults attain later life, they are more likely to be challenged with physical, mental, and social changes that require adjustment[3]. In particular, the oldest-old are increasingly vulnerable to declines in their functional capacities, resulting in a loss of autonomy[4].

Considering the varying challenges that occur from late adulthood to extreme old age and the high adaptive potential over the whole life course, aging was defined as an ongoing process which requires continuous adjustment[5]. Indeed, adjustment to aging (AtA) is reached by balancing one's own experience, self-standards, personal aims, core motivations and values, with external influences[6]. Moreover, AtA is different from other well-being concepts previously validated in the literature[7,8].

To date, insufficient attention has been paid to investigating AtA in older adults with age differences in the literature. Yet, given the diversity of aging experiences among the old and the oldest-old, the deepening of their perspectives by using qualitative research may provide an effective approach in differentiating AtA in both age groups[9]. Hence, how old and very old individuals perceive AtA was the central focus of this research. In detail, this is a qualitative study

☆ Conflicts of interest: All contributing authors declare that they have no conflicts of interest.

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designed to: (1) explore the conceptualization of AtA for the old and the oldest-old; and (2) examine the potential explanatory mechanisms of two correlational models for AtA for these age groups.

2. Materials and methods

2.1. Participants

One hundred and fifty-two, community-dwelling older adults were recruited from lifelong learning centers' message boards, local and art community centres list-serves in Lisbon and the Algarve regions in Portugal. Sampling was performed purposefully.

For the purpose of this study, old participants were aged between 75 years and 84 years and the oldest-old participants were aged ≥85 years. Furthermore, the professional status comprised all the professional development activities reported by the participants. Participants' target group were aged ≥75 years (mean = 83.76 years; standard deviation = 6.458; range, 75–102 years). The old participants were 59.2% women, 64.5% married, and 72.3% living with their family. The totality of old participants were able to perform activities of daily living, as well as instrumental activities of daily living. The oldest-old participants were 63.2% women, 59.2% married, and 82.1% living with their family. The totality of oldest-old participants were able to perform activities of daily living and 96.3% of these participants were able to perform instrumental activities of daily living. Participant eligibility criteria were the following: (1) an absence of concurrent severe mental disorders according to the Diagnostic and Statistical Manual of Mental Disorders-IV; and (2) scoring in the normal range on the Mini-Mental Status Exam (>26)[10]. Table 1 shows the characteristics of the study's participants.

2.2. Data collection

The participants were provided with a brief description of the study over the phone or in person, and were invited to participate in a person-to-person interview. All the participants gave their informed consent after the presentation of the study. Each semi-structured interview was performed individually in the participant' own home and began with a set of straightforward background questions to find out about the informant's living arrangements, health, age, family, education, and work, followed by one open-ended question: "I would like to understand what, in your point of view, contributes to your adjustment to aging in this phase of your life". During the interviews, the researcher assumed a neutral position in order to avoid bias in the investigation[11]. Neutrality was kept by ensuring that the findings were a function solely of the participants and conditions of the research, with no researchers' interpretation. The interviews lasted between 15 minutes 35 minutes and were conducted and audio-recorded by the same researcher, who had no previous relationship with the participants. Upon completion of the interview, participants were asked to evaluate the schedule and the interview process. The participants' private information was not shared without the individual's knowledge or against their will. Also, at no time were participants identified and they were free to withdraw from the research at any time without penalty. Participants' names were kept anonymous by using code names during interviews and filing of raw data. The selection process of participants was done fairly as each participant fitting the criteria had a chance of being selected. Benefits for participants included being given an opportunity to tell their perspectives in a positive, supportive environment in order to promote AtA in old age.

Table 1
Distribution of the study's participants according to sociodemographic and health-related characteristics.

	Old 75–84 y		Oldest-old ≥85 y	
	n	%	*n*	%
N	76		76	
Age (M; SD)	78.1 (2.196)		89.5 (3.696)	
Sex				
Women	45	59.2	48	63.2
Men	31	40.8	28	36.8
Education				
Primary school	17	22.4	24	31.6
Middle school	25	32.9	30	39.4
High school	27	35.5	16	21.1
University degree or higher	7	9.2	6	7.9
Marital Status				
Married or in a relationship	49	64.5	45	59.2
Widowed	20	26.3	27	35.5
Single	7	9.2	4	5.3
Professional status				
Inactive	41	53.9	47	61.8
Active	35	46.1	29	38.2
Family annual income				
≤ €10,000	15	19.7	26	34.2
€10,001–20,000	38	50.0	22	28.9
€20,001–37,500	16	21.1	25	32.9
≥ €37,501	7	9.2	3	3.9
Perceived health				
Good	48	63.2	41	53.9
Poor	28	36.8	35	46.1

M = mean; SD = standard deviation.

2.3. Data analysis

Data was analyzed, employing qualitative content analysis, and using the following procedure: (1) definition of major emergent categories, mutually exclusive, for the pre-existing category (indicators of AtA); (2) creation of a list of coding cues; (3) analysis of verbatim quotes of participants' narratives that better link to emerging categories; (4) identification of subcategories, while preserving the principle of homogeneity of the category; and (5) derivation of emergent categories, through constant comparison within and across interviews allowing for the clustering of related subcategories until the point of theoretical saturation was reached[12].

The approach to the analysis was based on an overarching concern for reflecting the participants' perspectives. To this end, the researchers decided on the word sense as the most appropriate unit of analysis as it would best reflect the participants' language usage and the style variations among the participants. The use of semi-structured interviews allowed the participants to reflect freely on their perceptions. The nominal variables were coded using an alphabetical code. The alphabetical code used the letters A–G, being that each letter corresponded to one category (e.g., "aging in place" = A; "health and body" = D). After categorizing the verbatim quotes of our participants, frequencies for each category were obtained by performing a word-frequency count. Additionally, a literature check warranted that there was a good fit between the reported data and pertinent literature.

An independent analysis of the 152 interviews was performed by a jury of two researchers (both faculty) and our structure of categories was then subjected to an external review. Critical feedback was obtained from two reviewers with experience with older adults. Establishment of the eligibility of the reviewers was ensured by the following criteria: (1) the reviewer had obtained a Masters degree in Health Psychology, which equipped her or him with knowledge in health and well-being matters; (2) the reviewer had investigative skills and health care experience with older adults;