

Psychological Well-Being in Later Life

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Introduction

Ageing can be considered in three fundamental ways:

First, as a process of physical and cognitive change where such factors as genetics, occupation, lifestyle, environment, diet, mental health, illness, disability, and life events can all have a considerable influence upon how our bodies function and respond to challenges in later life.

Research on biological ageing has identified several factors that influence the aging process. These include: accumulation in the body, over the lifespan, of pathological substances that trigger cell senescence (e.g. atherosclerotic plaques and amyloid proteins); disruption of regulatory pathways (e.g. as a result of frequent inflammatory diseases); mutations in mitochondrial DNA leading to poor energy metabolism; age corruption of the DNA telomeres that affect cell copying processes; and the pre-programmed cessation of stem cell renewal in late life.

Research into cognitive ageing suggests that, while there are wide individual differences in cognitive functioning in later life, people are likely to benefit from established wisdom and pre-existing skills and abilities. However, our speed of information processing, immediate recall, and word-finding ability are all likely to suffer reduced functioning as we age, particularly in those over eighty years of age. Accordingly, people affected with multimorbidities are likely to experience a greater range of adverse life events and outcomes, including lengthy hospital stays, frequent care transfers, poor quality of life, and increased mortality. Physical multimorbidity is strongly correlated with unplanned admission to hospital, particularly when also associated with existing mental health conditions and socioeconomic deprivation (1). *Second*, as a time of particular social and material change and transition in our lives, triggered for example by retirement, loss of loved ones, rehousing, and a satisfactory level of available financial and social resources. Thus, while older adults are often more experienced than younger adults in coping with major life events, they also face some of life's hardest challenges, such as chronic illness, disability, and bereavement. These factors, in addition to social context, cohort differences, and idiosyncratic coping styles, have a significant relevance to the presentation of older people in care settings and to working with them therapeutically (2).

Third, from an existential perspective, in terms of whether we experience our lives as being meaningful or meaningless in relation to our values, activities, interests, level of social inclusion, status, and value within the community, and in terms of our view of our lives as having been accomplished. According to Erikson (3), people are faced with

a number of psychological tasks throughout their lives, from birth to senescence, that support our personal and social development. These reflect trust, independence, accomplishment, identity, relationship formation and maintenance, contribution to society, and, finally, reflection from the age of 65 years on. This latter task reflects a need to retain one's sense of self-integrity or wholeness by considering one's life as having worth and by being able to accept the regrets in one's life rather than experiencing the sense of despair induced by the thought that one's life has been fruitless, insignificant, or morally deficient.

Within this perspective, how a given society views and responds to its older people plays a major role in the experience of being older and in the meaning we draw from our lives. The lack of meaning and purpose to one's life is a strong predictor of mental health problems, specifically in relation to depression (4), suicidal behaviour (5), and poor recovery from illness in older adults (6).

Drawing upon these perspectives, the term 'successful ageing' has been applied to reflect a field of study that explores predictive processes and mechanisms in late life that promote well-being and an adaptive ability. Rowe and Kahn (7, 8) have developed one of several models of successful ageing and define this as the ability to maintain a low risk of disease and disease-related disability by adopting a healthy lifestyle, high mental and physical functioning, and active engagement in life. Alternatively, Baltes and Baltes (9) suggest that successful ageing reflects our effectiveness at adapting to life's challenges regardless of health status and involves our ability to select and apply what we are good at while compensating for what we are least good at. They call this 'selective optimisation' and 'compensation'. Nevertheless, both the experience of growing older and the factors that influence it in positive and negative ways are complex and multifaceted and show a great deal of variation across individuals. Accordingly, the clinical problems and needs of older people admitted to acute care are often more complex and substantially different from those of younger people. Older people are more likely to experience a combination of multimorbidities as well as general frailty, polypharmacy, financial, social, and mental health problems (10).

In addition to the medical and psychiatric factors that trigger admission to hospital, many problems that affect an older person's well-being and quality of life may have been evident and building in intensity over time. These are often financial, social, or environmental problems, such as social isolation and loneliness, inadequate income or support, caring for other dependent people, struggling to maintain their home, and managing other demands in relation to their interests and activities (11). Accordingly, in assessing and responding to the needs of older people in hospital settings, significant challenges arise for clinicians and other professionals.

Understanding Psychological Well-Being in Older People

The psychology of ageing reflects a complex and often complicated interplay of biological, cognitive, emotional, behavioural, social, cultural, environmental, and economic factors that determine the experience of being older. Hence no single factor can be predictive of well-being and longevity in later life.

In later life, well-being is as much to do with *living a meaningful life* (an existential definition that reflects one's way of being in the world) as it is about *being well* in oneself (a biomedical definition that indicates being free from illness and disability) (12).

In addition, *quality of life* concerns those culturally and personally valued life domains through which well-being is experienced (13).

Accordingly, contemporary research on well-being and quality of life in later life suggests that well-being comprises of a number of principal properties or needs that enable people to experience their lives as contented and meaningful (12). These include:

1. **Integrity of self:** The range of intrapersonal characteristics (cognitive, emotional, and behavioural) that inform and influence the extent to which one can face and overcome major challenges and transgressions to oneself.
2. **Integrity of other:** Being concerned with and contributing to the welfare and quality of life of valued others.
3. **Belonging:** Attachment or connection to one's material, social, or spiritual environments and relationships that engenders commitment, closeness, inclusion, and involvement.
4. **Agency:** Both being able and having the opportunity to exert influence over one's life (and those of others) in accordance with one's personal choices and spiritual beliefs.
5. **Enrichment:** Engagement in activities and conventions that hold personal interest and serve to motivate, stimulate, and enrich one's life and give it moral worth.
6. **Security:** Adequacy of one's physical, mental, financial, spiritual, social, and material resources in securing welfare.

Quality of life domains that support well-being and psychological resilience in later life include: having good social relationships, which foster a sense of positive affirmation, respect, and value; having help and support when needed, both practical and financial; living in a home and in a neighbourhood that are perceived to give pleasure, security, meaning, and access to local facilities and services; engaging in hobbies, interests, and leisure activities; having a social role and maintaining social activities, including by contributing to the lives and well-being of others; having a positive psychological outlook and being able to accept circumstances that cannot be changed; having good health and mobility supported by a Mediterranean diet, exercise, and ongoing education; enjoying financial security and sufficiency to meet basic needs and enjoy life; retaining one's independence and control over one's life (14, 15).

Conversely, *ill-being* can be considered to reflect a life that is experienced as *meaningless* (16), where the following characteristics are salient:

- **A difficult life** (experiencing daily struggles with health, frailty, social isolation and loneliness, poverty, pain, and loss of independence);
- **A sense of purposelessness** (feeling that life lacks any purpose or meaning or that it is pointless);
- **Bitterness** (directed mainly at conditions and circumstances outside the self);
- **Negative self** (characterised by low self-worth, low self-confidence, and an abundance of self-criticism);
- **Negative world** (characterised by negative attitudes towards society and politics).

Meaninglessness is a strong predictor of mental health problems in later life, particularly depression (4) and suicidal behaviour (5, 17), and is also a predictor of poor recovery from illness (6). Conditions that give rise to the experience of meaninglessness in many older people often involve social exclusion or isolation, poverty, abuse and exploitation, loss of personhood, loss of independence and functionality, persistent and severe pain,

multiple transitions, cognitive impairment, and loss of purpose in life (14). This is particularly the case for those who are much older or who experience frailty and age-related decline in physical ability, multiple pathologies, and dementia and where admission to an acute medical ward is often the consequence of a minor stressor or illness that leads to a breakdown in the person's ability to care for him- or herself or to be cared for by others.

The Psychological sequelae of Illness and Acute Admission

The psychological sequelae of illness and acute admission to hospital in older people reflects a complex and dynamic interplay between *illness-specific factors* or *symptoms* and various *idiosyncratic* and *contextual variables* that influence an individual's response to illness and that would affect that individual's well-being, recovery, and readjustment, these are described in Table 1.1.

While illness-specific effects reflect key influences upon a person's presentation and ability to recover, there is a great degree of fluctuation that can be accounted for by *idiosyncratic variables*. These include:

- *Compounding physical and mental health difficulties or frailty, for example drug interactions.*

Around 25 per cent of adverse drug interactions are experienced by older people, particularly those with advanced frailty. Those who experience chronic anxiety, depression, and self-neglect are also likely to have poor immunity, while people who have suffered frequent infections are likely to show chronic fatigue and persistent pain (18).

- *Level of awareness.*

Many older people coming into acute care are, by their very nature, likely to be experiencing limited awareness as a result of distress, delirium, dementia, or other physical health problems that may affect their cognition.

Table 1.1 Illness-specific factors and their causes

Illness-specific conditions	Common causes
acute organic reactions/confusional states/delirium	<i>toxicity, anoxia, dehydration, shock, psychological trauma</i>
neuropsychological impairment	<i>stroke, dementia, cardiovascular insufficiency, respiratory diseases, raised intracranial pressure, space-occupying lesions</i>
situational anxiety/phobic reactions	<i>falls, general frailty, abuse/psychological trauma</i>
depression	<i>cerebrovascular disease/stroke secondary to long-term disability/treatment regimens, chronic pain after viral diseases, loss/bereavement</i>
behavioural disturbance	<i>acute organic reactions, CVA middle cerebral and anterior cerebral artery occlusions, frontal lobe dementias, brain cancer, substance misuse/addiction</i>

- *Ability to communicate effectively.*

Even in those who remain cognitively able, communication may be an issue by virtue of impaired motor functioning (dysarthria or dyspraxia after stroke, Parkinson's disease, etc.), depression, anxiety, fear, or even inability to speak English.

- *Compliance with treatment regimens.*

A person's ability to comply with treatment regimens, particularly where there are multiple and complex treatments of long duration, is likely to be limited. Compounding factors may also be present, for example motivation to live, existing frailty, responsiveness to treatment, nature and level of support from family and friends, and ability to engage with the treatment process.

- *Severity of handicap imposed.*

The impact that illness or disability has upon a person's life will be reflected in that person's identity, valued activities and lifestyle, and overall quality of life; in addition, it will be reflected in how it impacts upon that person's family and friends. For example, the loss of mobility will affect differently a person who values running and a person whose quality of life is grounded in writing.

- *Coping styles.*

There is now wealth of literature that evidences the significance of coping strategies or coping styles in influencing both a patient's response to illness and a patient's recovery from illness or adaptation to it. However, most patients in acute care settings are likely to face many challenges, which may require very different coping styles across a range of different domains – physical, functional, social, financial, and environmental.

Adapting to Hospitalisation, Illness, and Disability

Weiten et al. (19) have identified four main types of adaptive coping strategies that may be used generically across different illness scenarios.

Appraisal-Focused Strategies

These involve modifying the ways in which we may think or make sense of an experience. Often termed 'reframing', appraisal focused strategies often involve *challenging* people's views, beliefs, or understanding of their difficulties, orienting them towards a more positive attitude via education, demystifying beliefs, testing reality, or providing positive case examples. Such methods are a core component of cognitive behavioural therapy.

For example, a patient may believe that having a diagnosis of cancer means that one will inevitably die of it, thus developing anxiety or a sense of hopelessness and despair. Providing relevant information and education about treatment options and outcomes, lifestyle changes, and access to patients who have themselves recovered from cancer can all help to change the patient's negative appraisal of his or her illness and prognosis. Sometimes humour can be a very powerful way of reframing a situation or an experience. Psychologically, humour has the function of converting what could be viewed as violating or abhorrent events into benign or normalised events, thus rendering them more acceptable and providing an opportunity for sharing values (20).

Solution-Focused Strategies

Whereas appraisal-focused approaches aim to change the way a person makes sense of or thinks about his or her difficulties, solution- or problem-focused strategies are aimed at dealing directly with the triggers – the conditions that give rise to, or appear to be maintaining, the person's difficulties. Paradoxically, what people may identify as the problem can in fact be the *solution* to it. This idea is a central component of systemic or family therapy. For example, a patient may be frightened at the prospect of being discharged back home, even though he or she is medically fit. The reason may be fear of abuse perpetrated by the patient's spouse. However, for various reasons, the patient is reluctant to report this fear. Instead, the patient may locate the problem with going home in lack of confidence about being able to use his or her new assisted bath. In spite of various attempts by the occupational therapist to help the patient build reasonable ability and confidence to use the bath during home visits, the patient still maintains that he or she lack sufficient confidence to return home. Here the *problem* is that, by returning home, the patient is likely to experience abuse. Once abuse is recognised and thus identified as the problem, discharge planning can be more accurately and meaningfully developed with the patient.

Having identified the problem, a range of relevant and meaningful solutions are generated, then evaluated – either directly (in vivo) or by thinking it through (simulation) – on the basis of how effective, safe, and practical they are likely to be. The best solution is then accordingly attempted, ensuring that it is adequately resourced and supported; this will give it the best chance of success. The process may involve a degree of skill learning, accessing aids and adaptations, gaining the support of others, and so on (21). Taking control and being proactive is central to a problem-solving approach, and may also entail strategies that assist in anticipating and preventing future difficulties.

Emotion-Focused Strategies

Experiencing any range of emotions in the face of adverse conditions is a natural and essential aspect of being human. Emotions serve to communicate our status and needs to others, help us to express pent-up tension, grief, or anger, and can be important drivers to our becoming able to make necessary changes to our circumstances. However, emotions can also become overwhelming, disabling, and at times destructive. Some psychotherapists would argue that reactive depression involves the internalisation of anger (22).

In responding to and managing emotions, a number of non-destructive strategies or interventions can be helpful in addition to appraisal and problem-focussed strategies. These include *expressing emotions* (talking or confronting, crying, writing, sculpting, drawing, acting, playing music, running, etc.), *distraction* (reading, counting backwards, cooking, exercising, playing a computer game, cleaning, etc.), *distancing oneself* (non-engagement with the source or trigger of the emotion), *resolution* (conflict, hostility, guilt, blame, distance, hurt, abuse may require professional counselling, psychotherapy, or support), and *managing one's feelings* (relaxation, mindfulness exercises or meditation, physical exercise, compassionate acceptance, seeking comfort and affection from others; gaining sufficient sleep and having appropriate nutrition are also essential). On occasion, emotional distress may require professional help and support from

practitioners such as mental health nurses, the liaison psychiatry team, clinical and counselling psychologists, counsellors, and psychotherapists.

Occupation- or Activity-Focused Strategies

Occupation-focused strategies embrace a range of psychological components and processes that aim to address the impact of a person's illness or disability upon their functionality and physical and psychological well-being. Often directed by occupational therapists, the underlying philosophy that underpins the importance and benefit of occupation is the MOHOST (Model of Human Occupation Screening Tool) (23). The MOHOST assesses patients' motivation for activity, their occupational patterns, their communication and relational style, their motor skills, and the environment as reflecting the degree of congruency or fit between their functioning, their needs, and the environmental capability to support these needs. Strategies may involve discrete activities such as preparing a meal as well as more programmed approaches to assisting mobility, self-esteem, relational competence, activities of daily living, self-expression, cultural meaning, and so on (24).

While adaptive coping strategies are associated with recovery and improved quality of life, *negative* coping strategies are more likely to maintain, or even cause further disruption to, a person's existing status or situation. They often occur because of a number of reasons such as observing others – for instance parents, friends, or relatives who may have used similar methods at some point in their lives; paired association learning, where an action has led to a short-term benefit, then has become the norm; self-blame, self-hatred, or self-reproach; suppressed anger towards others or towards their illness or the impact it has had on one's life; pessimistic outlook or loss of hope that things could get better; other mental health issues (depression, psychosis, paraphrenia, dementia).

Examples of negative strategies are (25):

Overcompensation

- *Aggression/hostility*: Person counterattacks by defying, abusing, blaming, attacking, or criticizing others.
- *Dominance/excessive self-assertion*: Person controls others through direct means of accomplishing goals.
- *Recognition-seeking/status-seeking*: Person overcompensates by impressing, through high achievement, status, attention-seeking, and so on.
- *Manipulation/exploitation*: Person meets own needs through covert manipulation, seduction, dishonesty, or conning.
- *Passive-aggressiveness/rebellion*: Person appears overtly compliant while punishing others or rebelling covertly through procrastination, pouting, 'backstabbing', lateness, complaining, rebellion, non-performance, and so on.
- *Excessive orderliness/obsessionality*: Person maintains strict order, tight self-control, or high level of predictability through order and planning, excessive adherence to routine or ritual, or undue caution. They may devote inordinate amounts of time to finding the best way to accomplish tasks or avoid negative outcomes.

Surrender

- *Compliance/dependence*: Person relies on others, gives in, seeks affiliation, is passive, dependent, submissive, or clinging, avoids conflict, is people-pleasing.

Avoidance

- *Social withdrawal/excessive autonomy*: Person copes through social isolation, disconnection, and withdrawal. They may demonstrate an exaggerated focus on independence and self-reliance rather than involvement with others. Sometimes they may retreat through private activities such as excessive television watching, reading, recreational computing, or solitary work.
- *Compulsive stimulation-seeking*: Person seeks excitement or distraction through compulsive socialising, shopping, sex, gambling, risk-taking, physical activity, drug use, and so on.
- *Addictive self-soothing*: Person avoids discomfort through addictions involving the body, such as to alcohol, drugs, overeating, excessive masturbation, self-cutting, and so on.
- *Psychological withdrawal*: Person copes through dissociation, numbness, denial, fantasy, or other internal forms of psychological escape.

Well-Being in Relation to Culture, Faith, and Ethnicity

People from ethnic minority groups, particularly Pakistani, Bangladeshi, and Black African Caribbean people, tend consistently to report the poorest health, older people showing the greatest diversity in inequality across age groups (26).

But the relationship between ethnicity and well-being is complex in terms of the range of factors associated with the latter and the way in which they interact to affect health. Factors that have been identified across ethnic groups as having a significant influence on both physical and mental health and well-being include:

Socioeconomic Status

There is a wealth of literature on older people that clearly shows consistently poor socioeconomic status among Black minority ethnic groups in Britain (27). In older people, low socioeconomic status appears to have both a direct effect on well-being, via lower functional ability, depression, and disorders related to inadequate nutrition, and a secondary effect, through poor living conditions and social isolation.

Racial Discrimination

Burke (28) argues that racism maintains social and economic deprivation, limited access to care, and subordination to and social control by the majority culture. Littlewood and Lipsedge (29) go on to suggest that dominant cultures actively alienate people who do not belong to them. Such cultures lack an adequate frame of reference for understanding the experience, opinions, values, and needs of individuals from other cultures and hence are more likely to marginalise and socially exclude such individuals.

Social Support

Social support has been shown to have an important role in reducing the risk of depression after loss and in facilitating recovery from physical illness and disability

(30). There is also evidence to suggest that the nature and level of social support vary across ethnic minority groups (31, 32) and that, in addition, such variation accounts in part for differences in the levels of subjective well-being and suicide rates among ethnic minority groups (17).

Faith

Set in the context of spirituality and ageing, there exists a wide body of research identifying the role and importance of spirituality as a mediator of well-being in older people (33–35). Here spirituality is considered both as reflecting one's faith in a higher transcendent and as reflecting the ultimate meaning in life that derives from a person's sense of self-worth and relationship with others (36, 37).

Well-Being and the Hospital Environment

Over recent years there has been a growing body of research that has explored environmental effects upon recovery and prognosis. This has been influenced in part by a growing emphasis on patient perspective and engagement – as the experience of patients and their families is a key factor in service design and strategic planning – and in part by academic research, which has identified key aspects of care environments that can facilitate recovery and reduce the cost of inpatient care.

For the majority of older people, research suggests that the experience of hospital care, particularly acute care, reflects mainly high levels of satisfaction. Where negative experiences are reported, they tend to relate to staff attitudes, behaviour, and poor communication (38). Key themes include occurrences that involve deterioration in health or perceived poor care; unmet and unexplored expectations; difficult relationships with staff that pertain to poor communication and conflict over care. Older patients in the hospital may feel worthless, fearful, or not in control of what happens, especially if they have impaired cognition or communication difficulties.

Jurgens et al. (39) propose 'a cycle of discontent' in which events or crises are associated with expectations unmet by patients or their carers. When this cycle occurs, people become uncertain or suspicious, which leads to a period of 'hyper vigilant monitoring' in which people will seek out evidence of poor care, culminating in challenge, conflict with staff, or withdrawal. This scenario can itself become a crisis.

Concerning specifically the experience of hospital care by people living with dementia, a review of the literature suggests that there are mainly negative consequences and outcomes associated with these people's admission to general hospitals (40). Such consequences and outcomes relate to factors such as the hospital's physical environment – which can present significant challenges in terms of spatial location, lack of privacy, lack of familiarity and normative cues; co-morbidity in relation to both physical and mental health conditions; the type of interventions required; enduring multiple treatments; poor detection and diagnosis of illnesses and chronic pain; the failure of care staff to interpret behavioural communication and presentation as an expression of unmet need, distress, pain, or fear; and a culture of care that devalues people or that emphasises task focus and not person centeredness. All these factors increase the risk of long hospital stay, poor quality of life, falls, dehydration and malnutrition, functional decline, and death.

Developing a Positive Culture of Care

According to Bridges et al. (41), what these findings highlight is the importance of including the perspectives of older people themselves and their relatives in the planning and delivery of care in medical settings. They also lend support to the notion of creating a culture of care that is both personalised and relationship-centered. Factors reflecting such a culture of care would normally have the following components:

First, a *value base* informed from a person-centred perspective (42) that

- asserts the absolute value of all people, regardless of age, gender, ethnicity, physical or cognitive disability and places the individuals and their social relationships at the centre of services and interventions;
- recognises that people have a right to a dignified and meaningful life defined by themselves, regardless of illness or disability;
- recognises the unique nature of individuals, reflected in their identity, ethnicity, preferences, personal narratives, and life story.

Second, an individualised approach to assessment, treatment, and personalised care that

- is informed by an understanding of the perspective and experience of each individual, their story, and their lifestyle;
- focuses upon empowering the patient, their family members, and their friends, to have influence over their care and quality of life on the ward;
- creates personalised care plans that are co-produced and frequently monitored by both patients and their relatives;
- enables and supports positive and trusting relationships with care staff and other professionals;
- provides a well-managed treatment regime that considers and responds to the impact of the treatment upon the ability of the patient to tolerate and comply with it;
- minimises the need for excessive care transitions;
- seeks to maximise the patient's strengths and abilities regardless of the stage of their illness, or their capabilities;
- protects vulnerable patients from abuse and exploitation;
- enables and supports patients to take managed and normative risks (risk enablement);
- offers expertise, activities, and resources in partnership with patients and their families to achieve their goals and aspirations;
- works towards breaking down the barriers to discharge and re-homing;
- emphasises, considers, and addresses a range of factors that have an impact on a patient's well-being and personhood, including physical and mental health needs, functional ability, history, self-esteem and self-confidence, living environment, education and employment where relevant, and family and social relationships (43–45).

As applied specifically to professional person-centred practice, these principles can be usefully articulated under the acronym *CAREING*.

- C = *care* (with warmth, empathy, compassion, curiosity, and respect: care for and with patients, their families, one's colleagues, and the local community, thereby engendering a sense of value, belonging, containment, and continuity throughout).
- A = *accept* (people for who they are, and that they have the right to take risks; embrace risk as a necessary and meaningful condition of living; enable people to experience

meaningful and appropriate levels of risk regardless of illness, disability, or capacity: this is *risk enablement*).

- R= *restore* (and maintain self-esteem, self-confidence, personhood, and optimal functioning through the experience of valuing, affirming, supportive, and non-stigmatising relationships).
- E= *empower* (patients to remain in control of their lives and to make meaningful and relevant choices regardless of illness, disability, or capacity).
- I= *include* (patients and their families in decision-making, planning, and provision at all levels; ensure that their perspectives, opinions, and choices are embedded in everything we do).
- N= *nurture* (engagement in activities that provide a sense of meaning, purpose, and enrichment to life).
- G= *get to know* (patients from their perspectives, their culture, their life histories, and from those who know them well; renew your understanding of them each and every day, and through each and every challenge they face).

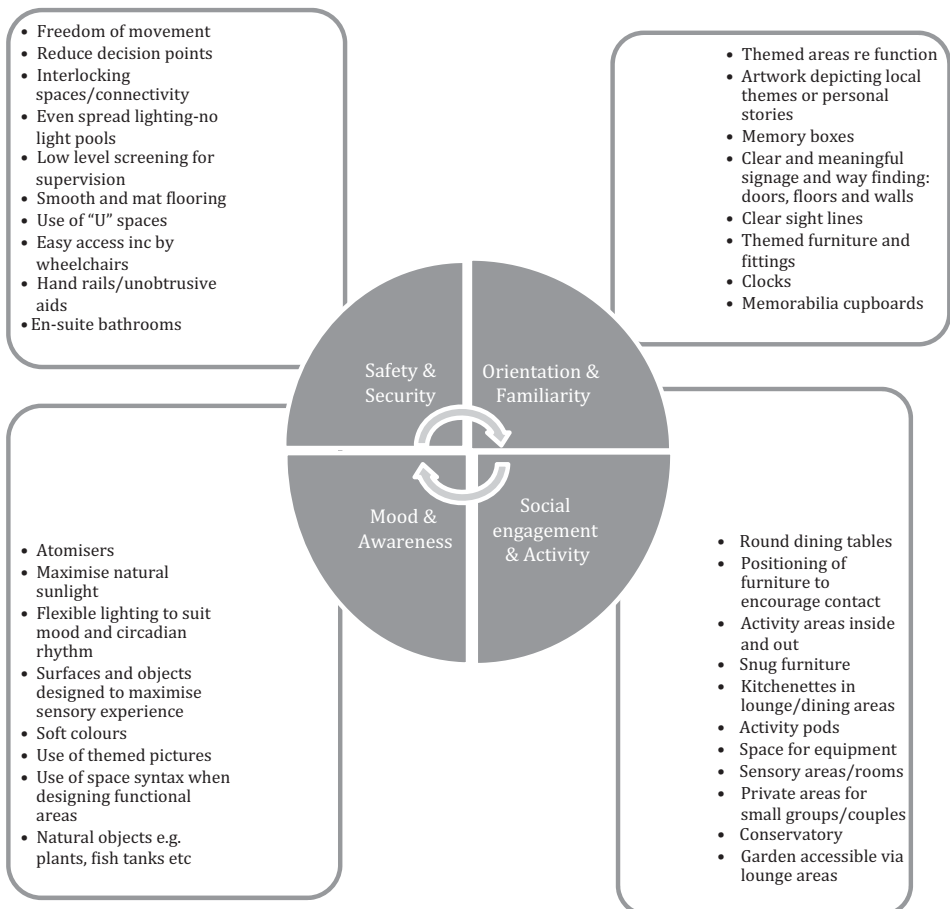


Figure 1.1 Environmental factors promoting recovery and quality of life on in-patient wards

Third, the provision of a *ward environment* that enables patients, their families, and their friends to feel safe and to have sufficient privacy and that offers sufficient opportunities for normative activities and experiences (46).

While there is now a wealth of research that identifies those models of care, interventions, services and ways of engaging vulnerable people, particularly those experiencing dementia, that make a positive difference to their lives and those of their families (47, 48), the physical environment has a large part to play in the well-being of those people and in the experience of their care (49). Environmental design characteristics that are known to play a crucial role in facilitating positive well-being and experience can be summarised in Figure 1.1.

Conclusions

Well-being in later life reflects two principal themes: first, that of *being well* in relation to illness and disability and, second, that of *being well* in relation to a *way of being* where life is considered to have meaning, purpose, agency, a sense of belonging, sufficient resources to meet one's needs (material, social, and financial), the resilience, personal integrity, and self-confidence for people to respond positively to its challenges, and the knowledge that those who we love are happy and healthy.

As we age, difficulties encountered in any of these areas can give rise to significant mental and physical health problems that may require hospitalisation. Both the difficulties a person may be experiencing before admission and those experienced within the hospital environment can further compound that person's health status and lead to poor recovery and, possibly, high dependency.

Factors predictive of a good recovery within hospital settings include positive relationships with family, friends, and hospital staff, a person-centred approach to care planning and delivery, meaningful and culturally relevant ward-based activities, regular monitoring of treatment regimens, a pro-recovery-designed hospital environment, continuity of care in the person's natural environment after discharge, and a staff team whose members are themselves physically and mentally well, are well supported and resourced, receive regular supervision and training, and are suitably protected from adverse ward conditions.

Understanding and responding to the needs and experiences of older people in acute hospital settings should never reflect an 'us and them' paradigm but should be driven by an 'us and us' paradigm. In this context, care provision is about delivering robust, evidence-based interventions, combined with empathic awareness, a commitment to working in partnership with patients and their families, and ring-fencing time for self-reflection. It's about being and caring *with*, not just caring *for*.

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