Quality of Life in Old Age: A Theoretical Perspective

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2.1 Quality of Life: State of the Theory

In view of the increasing number of older adults worldwide quality of life in old age has become an important issue for social, medical, and nursing care. "Add life to years, not years to life" is nowadays a well-established slogan. In this sense, the United Nations' second international action plan for ageing persons demanded the promotion of active ageing, well-being, and quality of life in old age (Fernandez-Ballesteros et al. 2007). Despite this relevance and despite the widespread use of the concept, its meaning has remained unclear. At a first glance, it refers to something we all believe to be familiar with: a good life. However, if people are asked to specify the meaning of such a good life, there is hardly any agreement that can be reached. In an attempt of clarifying the concept Halvorsrud and Kalfoss (2007) found more than 100 definitions of quality of life and more than 1000 instruments to measure it—either as a whole or in part. In the same way, Walker (2005) asserted in a review about quality of life and ageing in Europe that there is no consensus on definition and measurement. For some authors (Rosenberg 1995) the term encompasses several constructs. Other authors believe that quality of life refers to a single phenomenon that has several dimensions, i.e. physical, cognitive, emotional, and social aspects (Walker 2010; Rokne and Wahl 2011).

A clarification of the concept is important for two reasons: Nurses and caregivers are expected to promote the quality of life of care recipients. They can only do so, if they have a clear understanding of this aim. A concept clarification is needed to inform their practice. Furthermore, care providing institutions need to assess the degree to which they ensure quality of life among residents. Although nursing care is only one among several other factors that impact on quality of life, low quality of life may be indicative of apparent or latent problems that are experienced by residents and that need to be addressed by nurses and caregivers.

Beside its relevance for practice, conceptual clarity is also needed for research. The current lack of an agreed upon definition resulted in studies that aim to determine quality of life without even raising the question of how to define it. Reviews

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about quality of life ascertained that less than half of the studies purporting to investigate this phenomenon provided a definition of the concept (Halvorsrud and Kalfoss 2007; O'Boyle 1997). As a consequence studies measure different aspects and do not yield comparable results (Low et al. 2008). Furthermore, the same aspect may appear in one study as an influencing factor and in another study as a component of quality of life. With the increasing number of publications about this issue, it has become an increasing problem to distinguish between cause and effect and between aspects of the concept and its related factors (Rokne and Wahl 2011).

In view of the multitude of definitions some authors attempted to clarify the prevailing confusion by developing taxonomies. According to Farquhar (1995) there were global definitions, which refer to life satisfaction or happiness in general, component definitions, which specify subjective or objective aspects of quality of life, focus definitions, which are restricted to just one aspect such as functional capacity, and combined definitions, which include both general satisfaction and individual aspects (Farquhar 1995). This classification differentiates definitions according to formal aspects but is less informative about their content. Brown et al. (2004) suggested a classification according to the content of definitions with the following types: objective indicators, subjective indicators, satisfaction of human needs, psychological models, health and functioning models, social health models, social cohesion and social capital, environmental models, ideographic or individualized hermeneutic approaches. Some of these categories partly overlap (e.g. objective indicators include aspects which also are also part of health models and environmental models and satisfaction of human needs may also be considered as a psychological model), while other categories do not refer to different contents but to different ways of capturing it (e.g. subjective indicators and ideographic approaches). In sum, both approaches are not convincing and informative for practice. A typology of quality of life according to the content of definitions and based on a systematic approach is missing to date.

This chapter will give an overview of this still ongoing discussion. It will explore what experts for gerontological care (nurses, social workers, geriatricians, gerontologists, psychologists, etc.) believe to be quality of life in old age. It will compile their definitions, try to classify them, and discuss their advantages and shortcomings in order to offer a provisional definition of quality of life that may serve as a starting point for the subsequent investigations in this book. This chapter is based on the method of concept analysis according to Walker and Avant (2005) and identifies the current uses of the concept, determines their defining attributes, antecedents, and consequences, and provides model, borderline, and contrary cases for illustrative purposes.

Current uses of the concept were identified by a literature research in the databases MEDLINE, Cumulative Index to Nursing and Allied Health Literature, PsycINFO®, and GeroLit, the database of the German Centre of Gerontology. Papers published in the last 25 years and written in English and German were included. The investigated literature was composed of expert opinions, theoretical work dealing with the concept "quality of life in old age", surveys of quality of life

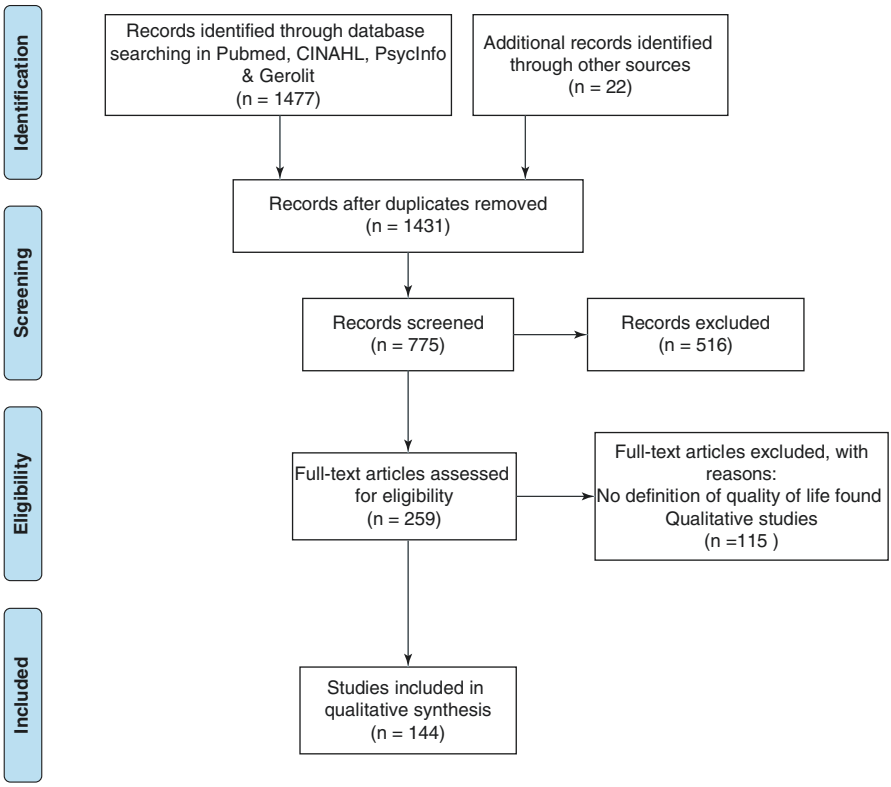

Fig. 2.1 Search strategy according to PRISMA (Moher et al. 2009)

in old age if they provided a definition of this concept, and psychometric studies on instruments to measure quality of life in old age if they provided a theoretical rationale. Figure 2.1 shows the flow diagram of the search strategy with the number of relevant articles according to PRISMA (Moher et al. 2009). Altogether 144 papers were included.

2.2 Quality: A Preliminary Definition

According to Webster's Online Dictionary the term quality has several meanings. It may refer to "an essential and distinguishing attribute of something or someone" or "a characteristic property that defines the apparent individual nature of something". In this broad sense quality of life would encompass all features that characterize the life of a person or a group of persons. The term may furthermore indicate a "degree or grade of excellence or worth". In this sense, quality of life is not simply a neutral description of a person's life but rather a judgement about the desirability of its condition. In literature on quality of life, the phrase is commonly

used in this way (Sirgy et al. 2006; Rokne and Wahl 2011). As a value judgement, quality of life may have four different meanings: quality of the objective life situation, general subjective well-being, subjective satisfaction of needs, or a multidimensional subjective state. In the remainder of this chapter these four meanings will be described and discussed regarding their respective advantages and shortcomings.

2.3 Quality of the Objective Life Situation

Quality of life as an objective situation refers to those circumstances of a person's life, which are considered by experts to be relevant for a good life and successful ageing (Smith et al. 2010). Regarding older persons the following components are said to be of particular importance: financial situation; living space including housing conditions, local environment, and transportation facilities; social relationships; health and functional capacities (Tesch-Römer 2002; Walker 2005). A typical case according to this definition would be an older person who had a good position before retirement and receives now a satisfying pension. Living in a safe and clean environment, having family and friends, and enjoying a good health are further aspects that contribute to a high quality of life. A contrary case would be an older person in lack of all these circumstances, and a borderline case would be a person who enjoys only some of these circumstances, while others are missing.

The main antecedent for a particular life situation is a person's biography as each component of this situation is acquired throughout the course of a person's life (Brown et al. 2004). Biography in turn is shaped by age, gender, socio-economic background, and culture. Critical life events such as diseases or loss of a partner impact on the objective situation additionally (Ferring and Boll 2010). The situation is furthermore influenced by all types of support and care that a person does or does not receive. The consequence of the objective situation is a degree of subjective well-being (Brown et al. 2004).

The apparent advantage of this definition is that quality of life can be determined by objectively measurable criteria. One simply has to obtain information about the monthly income, count the number of social contacts, perform a medical check-up, and investigate some environmental criteria like the distance between the place of living and important facilities for daily living. This approach, however, has a serious shortcoming. As quality of life implies a value judgement, someone has to judge how satisfying a certain income, a certain number of social contacts, a particular result of a medical check-up, and so on really is. Of course, 2000 Euro of monthly income are objectively more than just the half of it but the value of a particular sum of money depends on someone who attributes a value to this sum. In this way, for one person 1000 Euro may have the same value as 2000 Euro have it for another person. Hence, information about the objective life situation tells little about how good an observed situation really is with regard to quality of life.

2.4 Quality of Life as General Subjective Well-being

As a consequence of this criticism other authors suggest that quality of life is subjective in nature (Farquhar 1995; Raphael et al. 1995; Rokne and Wahl 2011). The WHOQOL Group summarized this point of view by defining quality of life as the "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHOQOL Group 1995, p. 1405). In other words, subjective standards provide a criterion to attribute value to the components of objective life situations. These standards may vary from person to person and the same objective situation may be judged in a different way.

The authors who take up this position often equate quality of life with subjective well-being (Spiro and Bosse 2000; Erlemeier 2009; Smith et al. 2010). They describe well-being as a general appraisal of life which has a cognitive and an emotional aspect (Veenhoven 2000). Cognitive appraisal is commonly called life satisfaction and affective appraisal shows itself as positive and negative emotion (Diener 2000; Smith et al. 2010; Ferring and Boll 2010). Hence "a person is said to have high subjective wellbeing if she or he experiences life satisfaction and frequent joy, and only infrequently experiences unpleasant emotions such as sadness and anger" (Diener et al. 1997, p. 25).

Life satisfaction as a cognitive appraisal is based on a comparison of one's current situation with personal goals and expectations (Brown et al. 2004; Weidekamp-Meicher 2005; Tesch-Römer 2010). Some authors add that life satisfaction has a temporal dimension as it may also refer to past and future expectations (Ferring et al. 1996; Kane 2003; Smith et al. 2010). Satisfaction with the past is the conviction to have made the best out of one's life, and satisfaction with the future is optimism and positive expectations (Lennings 2000).

Affective appraisal is composed of positive and negative emotions. Empirical studies found that these feelings were not simply the opposite ends of a single dimension but varied independently to one another (Bradburn 1969; Watson and Clark 1999). Bradburn explicates this finding with the example of a man who has an argument with his wife, which may increase his negative feelings without changing his underlying positive feelings.

A typical case of general subjective well-being would be a person who is satisfied with his life, feels happy most of the time, and rarely experiences anger or sadness. A contrary case would be the opposite, whereas a borderline case would be someone who claims to be satisfied by his life but cannot avoid feeling unhappy and sad for some time.

The antecedents and consequences of general subjective well-being can be summarized as shown in Fig. 2.2. The objective life situation is here an antecedent to well-being. It is perceived by the individual (indicated in Fig. 2.2 by the blue circle) and compared to his expectations (indicated by the arrow inside the circle), which depend to some extent on the person's disposition or habitual way of judgement (Leung et al. 2005; Brown et al. 2004; Diener et al. 1997). If expectations are met the person experiences well-being, whereas unmet expectations (indicated by the

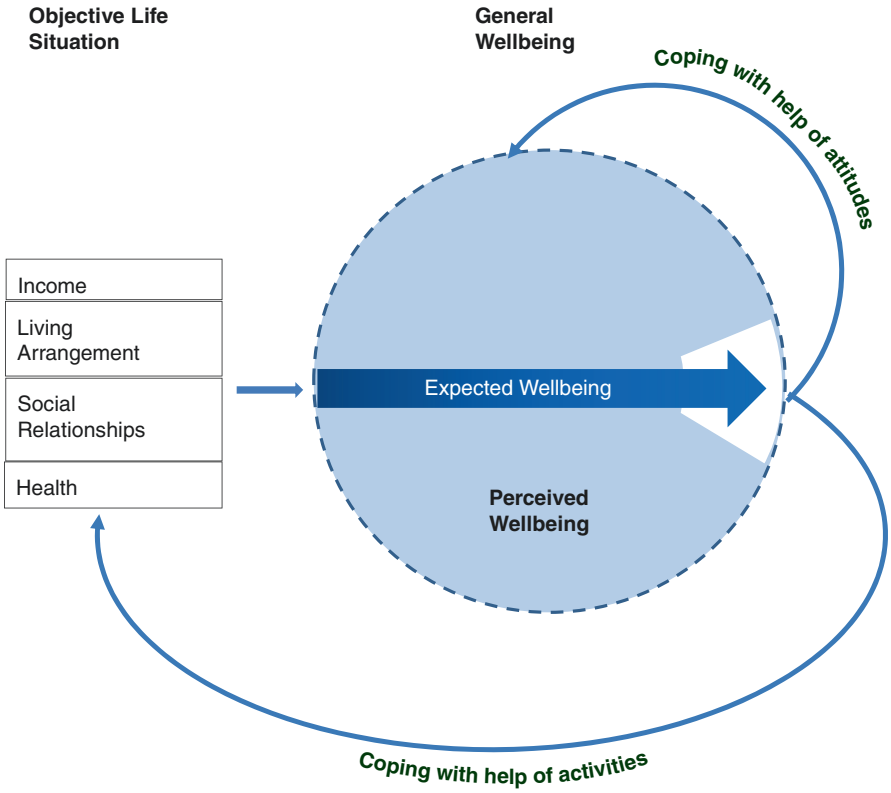

Fig. 2.2 Model of general subjective well-being

white area inside the circle) result in the opposite. This is, however, not a straightforward relationship. Several studies indicate that subjective well-being in old age remains stable despite losses and increasing limitations (Hendry and McVittie 2004; Ferring and Boll 2010). This phenomenon has been labelled satisfaction paradox (Walker 2005). It has been explained by a feedback process where low degrees of well-being produce coping reactions, which impact positively on the antecedents.

There are two basic coping reactions: coping with the help of activities aims at an adjustment of the objective life situation to inner expectations. Older persons try to improve health, social relationships, living arrangements, and income in an active way. They may engage in health promotion, maintain old and search new social relationships, reorganize their space of living, and earn additional money (Ferring and Boll 2010; Ebersberger et al. 2010). In contrast, coping with the help of inner attitudes is the adjustment of expectations to a given life situation (Leung et al. 2005; Erlemeier 2000). Older persons resort to this way of coping when they perceive that their abilities are decreasing. By lowering expectations they may maintain their usual level of well-being (Dietrich 2003; Hendry and McVittie 2004; Smith et al. 2010). A common mechanism of downregulation of expectations is

comparison with others (Hendry and McVittie 2004). The awareness that others are worse off increases the satisfaction of older persons with their own situation (Brown et al. 2004; Beaumont and Kenealy 2004).

As quality of life is perceived as a subjective phenomenon the definition circumvents the problem of how to attribute value to an objective life situation. This judgement is left to the individual. A further advantage of the definition is its simplicity. This, however, can also be seen as its major shortcoming because it may oversimplify quality of life. Satisfaction with life in general is a rather all-inclusive judgement that does not reflect the multifaceted aspects of a person's experience. It may also be the reason for the abovementioned satisfaction paradox. Limitations regarding some aspects may be compensated by improvements regarding other aspects so that overall satisfaction remains the same and changes that occurred remain undetected. In any case, general well-being does not disclose what it is composed of.

2.5 Quality of Life as Satisfaction of Subjective Needs

In response to this criticism some authors tried to provide a more detailed picture of subjective quality of life by equating the concept with need satisfaction (Wiggins et al. 2004; Weidekamp-Meicher 2005; Walker 2010). As there are several needs, overall well-being can be conceived as composed of these needs. It is the end sum of their satisfaction. Needs are considered to be universal and shared by all human beings (Higgs et al. 2003). At the same time, universal needs do not preclude individual expectations. The latter are rather individual expressions of underlying universal needs (Higgs et al. 2003; Sirgy et al. 2006). Persons have, for example, different preferences regarding their dishes but they share the same need for food. Needs provide thus a range in which individual expectations may vary and individual expectations are the concrete shape in which universal needs have to be met.

Regarding the question which needs are relevant for older persons gerontologists refer frequently to Maslow's theory (Walker 2005) who distinguishes between physiological, safety, love/belonging, esteem, and self-actualization needs (Maslow 1943). But there are also other suggestions for the classification of needs. Musslewhite and Haddad (2010), for example, propose a model with utilitarian, affective, and aesthetic needs. In terms of social pedagogy Obrecht suggested the categories of biological, biopsychic, and biopsychosocial needs (Ebersberger et al. 2010). To some extent the relevance of needs may be determined by culture (Holzhausen et al. 2009; Erlemeier 2009). Self-realization and self-esteem, for example, may be of higher importance in Western cultures with their emphasis on individualism (Leung et al. 2005), whereas harmonic relationships and fulfilment of family duties may be prioritized in Asian cultures where collectivist values prevail (Diener 2000).

An alternative approach to understand satisfaction of needs does not refer to needs directly but focuses on satisfaction with domains of life that are required to satisfy them (Ferrans and Powers 1992; WHOQOL Group 1995). Relevant domains for older persons are health and functional capacities, finances, living space,

availability of public transport, access to medical and social services, relationships to family, neighbours, and friends, social participation, and a positive attitude of society towards older persons (Winkler et al. 2006). These are basically the same domains as in the assessment of the objective life situation with the only difference that they are assessed now subjectively. Whereas the focus on needs captures the extent to which inner goals have been met and may be labelled as "satisfaction of", the focus on domains of life captures the extent to which a person feels that certain circumstances are suitable to achieve such inner goals and can therefore be labelled "satisfaction with". Although both approaches refer at the end to the same feeling of satisfaction, their components have no straightforward relationship. Satisfaction of safety needs, for example, may be related to satisfaction with finances or living space. The other way around, satisfaction with living space may be related to the satisfaction of safety or aesthetic needs.

A typical case of subjective satisfaction of needs would be an older person who eats and sleeps well and can satisfy her mobility needs. She feels safe in her environment, enjoys the company of family members and friends, feels respected by others, has a positive attitude towards herself, and perceives her life as meaningful. In sum, she is satisfied with her life. A contrary case would be a person whose needs have not been satisfied, whereas a borderline case would be someone whose needs are sometimes met and sometimes not.

As with general subjective well-being the objective situation is the antecedent to satisfaction of needs (Fig. 2.3). The variety of needs is symbolized in Fig. 2.3 by the arrows inside the circle. The satisfaction of each need results from a comparison of a current situation with a desired value. If there is no discrepancy between them, the needs of a person have been met (Ebersberger et al. 2010; Diener 2000). The final consequence is general well-being which is the sum of all satisfied needs (represented in Fig. 2.3 by the blue circle) (Diener 2000; Ebersberger et al. 2010; Zeman and Tesch-Römer 2009; Ferring and Boll 2010). A lack of general well-being (indicated by the white area inside the circle) produces feedback that provokes coping with the help of activities or inner attitudes. A reduced satisfaction of one need may furthermore result in an increased importance of another, which is less difficult to satisfy. Decreasing physical capacities, for example, may reduce the satisfaction of the need for mobility (Tesch-Römer 2002) but older persons may start to enjoy small things and obtain inner peace by focusing on religious or spiritual activities, which allow for a reinterpretation of life (Diener 2000). By these coping strategies the sum total of general well-being may remain stable even if particular needs are not satisfied.

In contrast to general well-being the concept of need satisfaction allows for a detailed portrayal of quality of life. The main disadvantage of this concept, however, is the lack of agreement concerning the needs that should be considered as relevant. Experts devised several lists of needs, and the final sum of well-being will vary according to the composition of these lists. At the same time it remains unclear to which extent these lists capture the perspective of the older persons themselves. It is furthermore debatable whether the satisfaction of different needs simply can be added to yield a total.

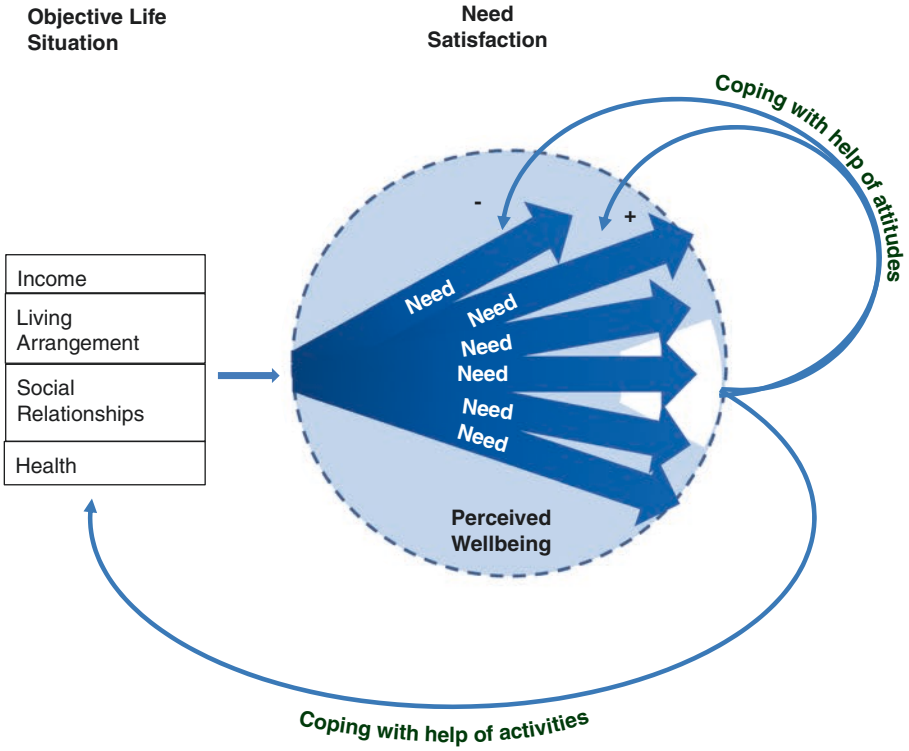

Fig. 2.3 Model of satisfaction of subjective needs

2.6 Quality of Life as a Multidimensional Subjective State

In response to the latter criticism some authors finally perceive quality of life as a multidimensional subjective state. The dimensions of this inner state are actually needs but they are considered to be independent of each other. Hence, if they were added to a total sum the assessment of quality of life would be misleading. Instead, drawing a profile in which each dimension is captured separately seems to be required. Life satisfaction, positive and negative effect are included by some authors in the dimensions of this inner state (Neugarten et al. 1961; Cheung 1997; Higgs et al. 2003), whereas others do exclude them (Ryff and Keyes 1995).

In addition, a variety of further aspects have been suggested as components of the multidimensional subjective state:

- Resolution and fortitude as "the extent to which someone feels responsible for his life" (Neugarten et al. 1961, p. 137).
- Zest, i.e. a certain "enthusiasm of response and degree of ego-involvement" (Neugarten et al. 1961, p. 137).

- Environmental control (Higgs et al. 2003) or environmental mastery (Ryff and Keyes 1995) which is the ability of managing the environment and making use of opportunities according to personal needs.
- Autonomy, i.e. the capability of independent decision-making and the shaping of one's life according to one's own idea and preferences (Ryff and Keyes 1995; Cheung 1997; Higgs et al. 2003).
- Positive social relationships (Ryff and Keyes 1995; Cheung 1997), i.e. being concerned about and having satisfying relationships with others.
- A positive self-perception (Neugarten et al. 1961) or—as Ryff and Keyes (1995) would label it—self-acceptance.
- Purpose in life (Ryff and Keyes 1995; Cheung 1997) which refers to feelings of being useful and having a deeper meaning in life.
- Personal growth (Ryff and Keyes 1995) which means a feeling of continued development and openness to new experiences—an aspect which was labelled self-realization by Higgs and Hyde (Higgs et al. 2003; Hyde et al. 2003).
- Finally, meeting ethical obligations and social duties are said to be important for a good life (Cheung 1997)—at least in collectivist societies where people in contrast to individualistic Western cultures are more likely to sacrifice personal happiness to fulfil their duties (Diener 2000).

A typical case for a high quality of life as a multidimensional subjective state cannot be constructed as the dimensions of this concept do not yield only one total sum. There will be rather different types of high quality of life—some regarding general satisfaction, others regarding social relationship, purpose in life or fulfilment of duties, and so on.

Like in the two previous models, the objective life situation is the antecedent of quality of life as a multidimensional subjective state (Fig. 2.4). However, a comparison between expectations and perceived satisfaction does not result in an overall perception like general well-being. The components of the multidimensional state do not necessarily compensate one another if one of them is less satisfied. Each dimension is an end point in itself and has to be considered separately. Hence, every component has its own way of coping either with the help of activities or with the help of inner attitudes. Some components may be even in conflict with another. Ryff (1989), for example, argues that people may strive for a purpose in life and personal growth while ignoring at the same time that this may at least temporarily reduce their general well-being.

The advantage of defining quality of life as a multidimensional subjective state is that it allows drawing individual profiles of quality of life while avoiding futile discussions about which profile implies a higher level of quality in general. However, like in the previous concept there is no agreement upon the dimensions of quality of life as a multidimensional inner state. It is furthermore debatable that the dimensions of quality of life are completely unrelated. Their interplay remains an open question that needs further investigation.

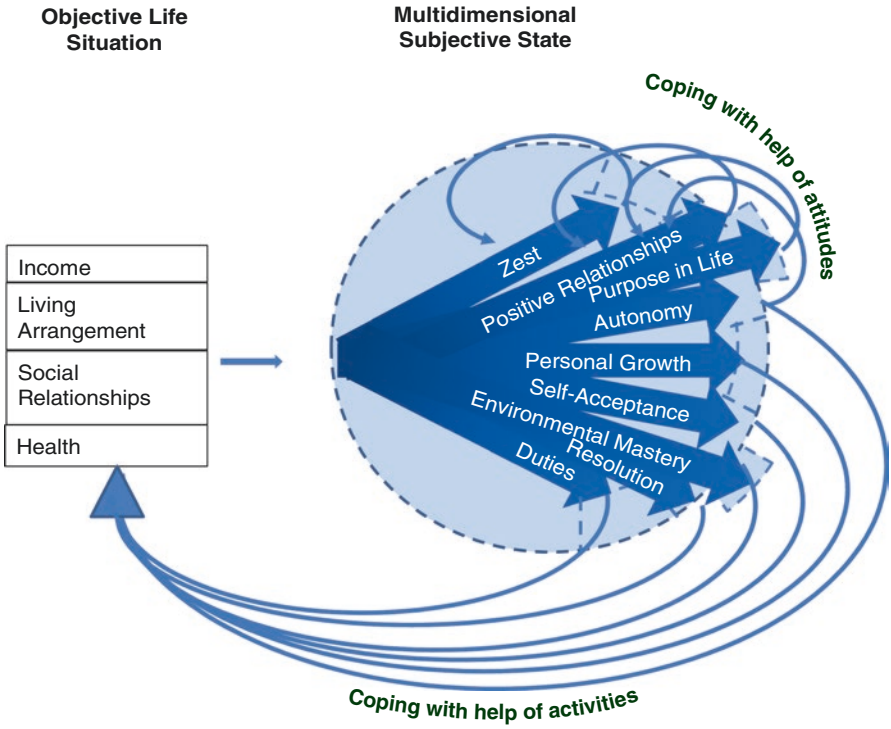

Fig. 2.4 Model of multidimensional subjective state

2.7 Quality of Life: A Person-Centred Approach

To sum up, there are four different definitions of quality of life. However, little agreement exists regarding their components. They provide rather broad categories that allow a classification of the different ways how experts use and understand this concept. Three definitions concur that quality of life is a subjective state which results from objective circumstances and depends on the attitudes and expectations of older adults. However, the particular components of quality of life as suggested by these definitions are based on the assumptions of experts. If the perspective of older person really matters, the best way to determine the components of quality of life will be to ask the people who are concerned. In other words, to determine the meaning of quality of life requires a person-centred approach.

A person-centred approach aims to provide care and support in a way that puts people at the centre of decisions. It is based on the conviction that persons have central concerns according to which they shape their lives. As the German philosopher Heidegger would put it: A person (which he labels in his terminology as *Dasein*) is an "entity for which, in its Being, that Being is an issue" (Heidegger 1962, p. 236). Whatever a person does, it matters to her and has a meaning for

herself. That what matters to her are her desires, values, and needs that have evolved in interaction with the social and environmental conditions of her life. It follows that quality of life is experienced when a person achieves what matters to her. Hence, to define quality of life a person-centred approach will start with asking people to tell us what they are concerned about—as it is done in qualitative studies. Instead of determining *the* meaning of quality of life in general, this approach will identify *their* meaning of this concept. The investigation should start with the experiences and needs of community-dwelling older adults. Living independently like most of us, they are able to convey the original perspective of persons who are not affected by the experience of receiving care. Based on a metasynthesis of qualitative research their perspective will be described in the following chapter. The subsequent chapters will explore how the perspective of older persons and their experience of life may change if they receive some kind of care.

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