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Introduction to the Second Newsletter of the Growing Older Programme: Defining Quality of Life

Growing Older is an ESRC research programme focussing on the key question of how the quality of people's lives can be extended. Everyone knows that years have been added to life but, in common with other ageing societies, the UK still faces the challenge of adding quality life to those additional years.

The Programme consists of 24 projects spread across six topics that are central to extending quality life: defining and measuring it; inequalities in quality of life; technology and the built environment; healthy and productive ageing; family and support networks; and participation and activity in later life. The Programme runs from 1999 to 2003. The first project started in September 1999 and the last a year later. The first project to finish will be in April 2001 and the last in March 2003. The GO Programme boasts some of the UK's leading researchers on ageing and related issues but is also a training ground for new researchers. In all 96 researchers are working on the Programme.

The first newsletter provided a profile of the projects while this one focusses on a substantive topic: defining quality of life. There are many different perspectives on this issue and the Programme has not tried to impose a particular one. Instead this newsletter provides a sample of some of the different perspectives with the intention of both providing information and stimulating debate.

Alan Walker
Programme Director

Older People's Views on Quality of Life

Ann Bowling, Zahava Gabriel, David Banister, Stephen Sutton

Quality of life is a multi-level and amorphous concept, despite its popularity as an endpoint in the evaluation of public policy (e.g. outcomes of health and social care). It reflects objective, macro socio-demographic influences and more subjective micro concerns, such as individuals' values, all of which pose challenges for measurement. Most disciplines have based their measures on expert rather than lay opinions.^{1,2} Therefore, there is little data on how much relevance these measurement scales have to people's lives.

ADDING QUALITY TO QUANTITY IN LATER LIFE

To gain a national and representative sample of about 1,000 older people, the Office of National Statistics (ONS) Omnibus survey was used as a means to obtain basic information on individuals, and this was supplemented by a follow-up in depth survey. All respondents aged 65+, who agreed to be re-interviewed, later completed the study's quality of life module. The main survey included mainly structured questions and scales (e.g. to measure psychological well-being, health status) along with the following six open-ended questions about quality of life:

- 9a) First of all, thinking about your life as a whole, what is it that makes your life good - that is, the things that give your life quality? You may mention as many things as you like.
- 9b) And what is it that makes your life bad - that is the things that reduce the quality in your life? You may mention as many things as you like.
- 9c) Thinking about all these good and bad things you have just mentioned which one is the most important to you?
- 9e) And what single thing would improve the quality of your life?
- 9f) And what single thing, in your opinion, would improve the overall quality of life for people of your age?

This short article examines the responses to Q.9a) in the first and second surveys.³

RESULTS

Health

Respondents frequently made downward comparisons in relation to others' health (including their parents' in the past):
Seeing other people who are not well makes me feel lucky that I still have good health.

In some cases, people prioritised their health because of previous illness:

I had a triple by-pass three years ago, and you are thankful to be still alive.

Others prioritised their health because it was essential to their continued enjoyment

of life (i.e. being fit enough to do what they wanted):

Good health - I have it. I think we both do. Being able to get about and do what I want.

Independence

Independence was commonly viewed as an essential feature of quality of life. Most people valued their independence and emphasised health and financial resources enabling them to maintain it:

Having my health and having a reasonable standard of living. Well they both give you the freedom to do what you want. You are not dependent on anyone.

In particular, being fit enough to drive and/or wealthy enough to run a car was stressed:

The car - it makes my quality of life. It allows me to travel to our caravan, or to get to the seaside to allow me to breathe better. It allows me to go shopping. I feel I have made the quality of my life before retiring - home and, in my car, the second home - caravan. I am unable to walk far... and the car gives me independence to get about.

Lack of time constraints due to retirement was also valued:

...If I decide I'm going to spend all day in bed and have bacon and eggs at 2am, and go on holiday, or have a new suit, I can do them. Freedom from pressure. I've done stressful work and that's been taken away and I'm happier for it.

Social relationships

Social relationships with family, friends and neighbours were important to people for companionship and practical help:

My daughter takes me shopping now... if I need anything I've only got to say. I've got another daughter... and she'll do anything to help. My sons-in-law are good... and they'll always do a job for me, if there's any heavy work to be done in the garden... although my next door neighbour is very helpful too. He did a big job at the back for me.

Active and reciprocal relationships, particularly being 'good' grandparents were also emphasised:

The quality of my life now is my family - my children and grandchildren. I go at weekends, they visit every week. Sometimes I have the younger grandchild staying overnight. They make sure I'm not alone at weekends because I'm on my own through the week... I'm there if they need me. I get them bits for their flat and make them more comfortable. I knit them big jumpers and just look out for them.

Financial circumstances

Respondents often compared themselves favourably with people they perceived to be worse off and did not make comparisons upwards:

Having sufficient income to do what I want... Having enough money - without being rich - makes me privileged compared with my parents.

Having enough money for participation in society - especially for pastimes and going away - was frequently mentioned:

Freedom - the ability to do what I want and go where I want with my husband and family. Having enough money to do what I want. We go to play bridge, go dancing, play bowls.

Home and neighbourhood

The area's neighbourliness, safety and facilities were recurring themes:

It's a good neighbourhood. If people see you they go out of their way to talk to you, you don't have to want for anything.

Ah! Yes, living in a community where you feel safe. Yes nowadays all the news seems to be about old people being mugged or robbed and round here thankfully there is very little trouble like that.

Just thinking, very fond of our little library... and that brings a lot of pleasure, it's excellent.

Social activities and roles

Participation in social, educational and local voluntary activities to 'keep busy' was also important:

Well, I think being busy really. I'm keen on repairing things and do-it-yourself... I play snooker three or four times a week and two evenings I have a couple of pints. I think I'm pretty easily satisfied.

CONCLUSION

Contrary to doubts about the feasibility of measuring quality of life,⁴ the above results indicate that older people can define what constitutes good quality of life. This supports previous research⁵: while health and functioning are the most frequently mentioned areas of life, social support, security and safety, adequate finances, and independence are also important. In particular, social, educational and local voluntary activities were reported to be important. ►

Defining Quality of Life

Allison Smith

The term 'quality of life' is ambiguous. On the one hand there is the quality of an individual's life, a reflection of how well his (sic) life is going; but there is also a broader concept, capturing roughly the quality of the living condition around the agent.¹

Operationalising quality of life presents social scientists with an impressive challenge. It is a dynamic multi-dimensional concept, which has the potential to differ both between individuals and within a person's life-course. Most current definitions of quality of life tend to encompass both objective (e.g. income, employment, health) and subjective (e.g. happiness, life satisfaction) elements. Bowling (1995), for example, takes quality of life 'to encompass in a broad sense the social, psychological and physical domains of life, incorporating a subjective assessment of important life domains in relation to achieving satisfaction'.² Similarly, Lawton (1991), in a more abstract way defines quality of life as a 'multidimensional evaluation, by both intra-personal and socio-economic criteria of the person-environment system of the individual'.³ Other researchers have preferred to question the philosophical reasons behind humans' quest for quality of life. Researchers at the Quality of Life Research Centre in Denmark, for example, believe that between objective and subjective measures - which they refer to as 'superficial poles of existence' - 'an existential core of experienced life meaning can be found, where the subjective and objective meet and the source of quality of life is found'.⁴

Deciding how to measure quality of life is just as complex as agreeing on how it should be defined. The most prevalent types of measure are those related to health and quality of life from the medical sciences.^{5,6} Within the social sciences, measures tend to cover a broader range of instruments and encompass a wide range of variability. For example, quality of life measures range from standardised quantitative instruments like the Philadelphia Geriatric Centre Morale Scale⁷ and Diener's Satisfaction with Life Scale⁸ to open-ended, semi-structured questionnaires.⁹ Variables measured tend to encompass health, social and economic dimensions.

Social science findings relating to quality of life are comparatively fewer in number to results from the medical sciences, especially with regard to older people. Nevertheless, some of these studies have begun to reveal some of the possible determinants of quality of life. Health,^{1,9,10} finances,^{1,9,10} neighbours/neighbourhood,^{10,11} local services,¹¹ safety¹¹ and social contact with friends and family^{1,9,10} have all been mentioned as important factors for sustaining quality of life by older persons.

These findings are supported by initial evidence drawn from one of the 24 projects funded under the Growing Older Programme. In order to develop a better understanding of what quality of life means to older people, researchers at Keele University engaged older people in a series of group discussions in different regions of England.¹³ Participants were asked a series of open ended questions about the good and bad things which aid and/or take away from their quality of life. Being physically healthy, having enough money, social support from family and friends, activities to participate in, and safety of neighbourhood were all mentioned as influencing their quality of life:

It's not the quality of life is it? It's the quality of disabilities. I mean, if you can walk, if you are able to do everything, your quality of life when you're a pensioner is good. (Liverpool)

I can sum it [quality of life] up in one word 'income'. With income you can do all them things, without it you can do none of them. I mean, somebody mentioned good health and all that lot. We've also mentioned leisure centres. But to get to a leisure centre you need money. You're in a Catch 22 because you need the money to go to the leisure centre to keep fit to be an old age pensioner. (Central England)

measures (which focus on more than health and physical functioning) when investigating the well-being of older people. ■

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See we've got a family that's there all the time you see. I've got a son and daughter that's home all the time. (Manchester)

There was nothing good. The only good thing is that once a week we assemble here and we all get together and talk. Once or twice a week we are happy. (Newham)

These initial findings have helped researchers engaged on the project begin to understand some of the determinants of quality of life. As yet there is no single recognised definition or measure of quality of life. Quality of life needs to be understood within the context of a study's aim and objectives. This will influence and guide researchers towards the use of objective or subjective measures or a combination of both. ■

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continuation of 'Older People's Views..'

This research also supports the relevance of psychological theories (such as social comparisons and independence) to quality of life research. Respondents commonly made downward health and wealth comparisons, without prompting. This research therefore indicates the need for broader quality of life

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Spiritual Beliefs and Existential Meaning in Later Life

Peter Coleman

This project examines 'spiritual well-being', an aspect of quality of life that has been surprisingly neglected by recent British studies of ageing. This contrasts greatly with the USA where the subject of religion and ageing is a popular theme in the annual conferences of the Gerontological Society of America. Moreover, there is a consistent body of American research which demonstrates the benefits of religious activity to health and well-being.¹

One reason for this difference is the much lower level of allegiance to Christian denominations in Britain. This is due to the falling rates of membership of churches, which appear also to have affected the older age groups.² But declining religiosity is in fact a reason for taking the spiritual needs and spiritual well-being of the population more rather than less seriously. For, despite the declining church attendance most of the general population claim to believe in God. However many profess belief systems which are often eclectic, unstructured and unsupported. As Heelas notes in his discussion of contemporary religion³:

Rather than authority and legitimacy resting with established orders of knowledge, authority comes to rest with the person... What the tradition used to demand has transformed into lifestyle options... Thinking of the significance of this for religion, postmodern religion... is very much in the hands of the 'free' subject... The de-regulation of the religious realm, combined with the cultural emphasis on freedom and choice, results in intermingled, interfused, forms of religious - or 'religious'-cum-'secular' - life which exist beyond the tradition-regulated church and chapel. People no longer feel obliged to heed the boundaries of the religions of modernity. Instead they are positively encouraged to exercise their 'autonomy' to draw on what has diffused through the culture.

This loss of rootedness in tradition may result in problems for people in crisis situations, as they often lack the support systems for their beliefs provided by conventional religions. One area of work which has accepted this typically post-modern dilemma is palliative care. Spiritual care has long been recognised as a key element in the total system of care provided by palliative care services. But it is also increasingly seen as more than just providing access to religious ministry. In his elucidation of the task of pastoral care in the health care field, Peter Speck,⁴ provides

an explicitly non-religious definition of the word 'spiritual' as 'relating to the search for existential meaning within any given life experience, with reference to a power other than the self, which may not necessarily be called "God"'.⁵

It is from this perspective that in our current project we are seeking to study beliefs in late life. We use the working definitions and questionnaires that Peter Speck has developed, in conjunction with the psychiatrist Michael King, to distinguish religious, spiritual, and philosophical belief systems.⁵ This means that we accept that not everyone has a spiritual belief system. It is important to note that there is a wide variation in definitions of 'spirituality' in use today. Most commentators, including ourselves, suggest that belief in a transcendent power or reality is a key feature of spiritual belief. But some use the term to encompass issues of value, meaning and relationship without implication of transcendence.⁶

Our working definition thus allows for non-spiritual answers to questions of existential meaning. As Peter Speck states:

Does the fact that you and I exist have any meaning and purpose at all? If so, what is that meaning, how do I discover it and does it change over time? These are ultimate questions which will challenge in a variety of different ways and may only be addressed at key moments in a person's life when perhaps our very existence is being threatened, or we are undergoing some significant life change which touches on our identity.⁷

Late life provides such challenges and therefore it is particularly important to include perception of ultimate sources of meaning in consideration of older people's quality of life.

We have chosen to carry out an exploratory study into older people's belief systems as

to existential meaning in the context of the experience of bereavement of a spouse. Research in the field of bereavement has not yet taken account of the complexity of spiritual belief. Most studies have focused on religious practices rather than belief *per se*. Yet it is clear that praying, belief in God, and trust in a re-union in the afterlife are sources of comfort and hope independent of religious allegiance.⁸ Many also report that continued contact with their deceased spouses, through a feeling of their presence or through internal conversations also help. We intend to give particular attention to the nature, variety and origins of such beliefs and their relationship to indicators of subjective well-being. We also intend to examine the support available to them and their stability over a one year period from the first to the second anniversary of the death.

A recent report of the Centre for Policy on Ageing in London has drawn attention to the neglect of religion and spirituality in British gerontology.⁹ It concludes with a discussion of the implications of research in this field for policy makers, and whether providers and policy-makers should extend their working definition of well-being in later life to include a spiritual dimension. As the author points out, if older people have traditionally turned to religion to answer their existential concerns arising from ageing, what happens when, as is the case in contemporary Britain, the institutions of contemporary religion and their influence have declined so dramatically? This is the focus of our enquiry. ■

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Assessing Ethnic Inequalities in Qualities of Life

Ini Grewal and James Nazroo

The post-war period, particularly the 1950s and early 1960s, saw significant numbers of relatively young people migrating from the Caribbean and Indian sub-continent to the UK. Many of these people were actively recruited into the UK to work in the manufacturing and public service industries that faced a shortage of labour. Since migration these groups have made a major contribution to the UK's economy, but they are now progressing into early old age and retirement. They are a generation with a unique history, different from previous and future generations, from whom we can learn a lot, but also a generation whose needs are current. With one or two exceptions, however, the circumstances of older ethnic minority people in Britain have not been a key issue for either policy or academic work, possibly because they are considered to be a small population whose needs will be met by their families.^{1,2} The study we describe here³ sets out to contribute towards filling this gap in knowledge, in particular by attempting to map and explain ethnic inequalities in quality of life.

Existing evidence suggests that ethnic minority people of all ages fare worse than the general population on a number of dimensions, including economic position and health.⁴ And some of this evidence suggests that this disadvantage may get worse with increasing age. For example, there are only small ethnic differences in health among young adults, but by late middle age people in all ethnic minority groups report worse health than white people.⁵ Indeed, it has been suggested by some commentators that older ethnic minority people face 'multiple hazard',¹ with the suggestion that having an ethnic minority background in addition to being older adds extra dimensions of disadvantage. However, in other ways some ethnic minority groups may do better, for example older ethnic minority people are more likely to live with, or close to, their children.⁴ And there is likely to be considerable diversity both across and within ethnic groups in quality of life, as there is for more specific outcomes.^{4,5,6}

But existing approaches to analysing quality of life may tell us little about ethnic inequalities. Its highly subjective nature means that perceptions of what is important to quality of life are likely to be culturally informed. So the nature and relevance of particular dimensions of quality of life will vary across ethnic groups. For example, broadly speaking family contact may be more important for some ethnic groups than others, and the notion of autonomy may carry very different meanings for people in different ethnic groups.

OUR METHODS

Central to our approach to investigating these issues is a qualitative study concerned with investigating ethnic differences in the ways in which people experience quality of life. Here we are interviewing respondents from four ethnically homogeneous groups (Jamaican, Gujarati Hindu Indians, Punjabi Pakistanis, and white English) with diverse experiences, with the intention of exploring how far there might be differences in definitions and meanings of quality of life across these culturally different groups. Our expectation is that using groups that are as homogenous as possible will maximise the possibility of finding differences between them. We consider the inclusion of a white English group to be crucial, both to provide a point of comparison (ensuring that difference is not essentialised to supposed racial or ethnic characteristics) and so that white ethnicity itself could be a focus of investigation, rather than ignored.⁷

The qualitative interviews are being conducted in the language(s) of the respondent's choice, imperative in enabling full expression of complicated ideas and emotion.⁸ In some, but not all, cases, gender matching of the interviewer and the respondent is being used, an approach that will allow us to explore the methodological implications of matching. The interviews themselves will focus on: biography; current circumstances; current activities; and definitions and views of old age. Throughout we will be encouraging respondents to talk about the things that bring quality to, or limit the quality of, their lives.

We then plan to use these qualitative data to inform the quantitative analysis of an existing data set (*the Fourth National Survey of Ethnic Minorities*⁴) in order to map ethnic inequalities in quality of life, in a way that is sensitive to the views of older people themselves and how these views might vary across ethnic groups.^{1,9} A second purpose of the qualitative study is to explore the biographies of the people we interview, to enable us to understand how and why people have reached their current position. This life course perspective will allow us to explore the mechanisms that might underlie ethnic inequalities in older ages.¹⁰

IMPLICATIONS

Research into ethnic differences in the meaning and experience of quality of life for older people promises great dividends, both in shaping policy and in theoretical developments. We have already pointed to the lack of information to inform policy. In addition, an exploration of ethnic inequalities among those post-retirement will allow us to sharpen our theoretical understanding of the contrast between the structured dependency and third age approaches to ageing.^{11,12,13} An understanding of how far ethnicity might interact with the institutions that promote dependency among older people, and how far the dimensions and very notion of a third age might be culturally bound, will be an important outcome of this study. ■

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Defining Quality of Life in Lay and Professional Terms

Christopher McKeivitt

The concept of the quality of life has been traced back to Aristotle and his concern to identify what makes for a good life. In one interpretation, the idea of quality of life requires consideration of the nature of humans and the social requirements for their flourishing.¹ In health research, quality of life investigation is comparatively recent. According to the *British Medical Journal*, while quality of life research was unknown 15 years ago more than a thousand new articles on the subject now appear in medical journals each year.² This can be related to several factors including increased interest in seeking consumer views of health care, the rise of evidence-based medicine requiring outcome indicators and pressure to increase resource use efficiency. Yet, the ascendancy of the quality of life concept is also a little surprising given the almost universal acknowledgement of the difficulty of saying precisely what it means.³

PROFESSIONAL PERSPECTIVES

Some use the term in a sense not too dissimilar from the Aristotelian. The sociologist Strauss summed up his interest in chronic illness: 'In the terminology of an increasingly popular phrase: how is the quality of life affected by having a chronic disease?' He was explicitly interested in investigating chronic illness in terms of its impact on people and their families in their own environment.⁴ In 1966 quality of life was defined in a US medical journal as 'the harmony within a man, and between a man and his world'.⁵ More recent researchers proposed narrowing the definition of quality of life considerably, explicitly excluding factors such as life satisfaction and living standards.^{6, 7} Use of the term *health* related quality of life has been advocated as proper to clinical research. In this sense the concept refers to an outcome, either the impact of an illness, as perceived by the person with the illness, or the patient's view of the impact of an intervention to alleviate an illness or condition.

In stroke research, quality of life is an important consideration since stroke frequently changes people's lives in terms of their ability to work, to get out and about, even to perform basic tasks. Four main domains of quality of life for stroke patients have been identified as physical health, functional ability, psychological well-being and social functioning.⁸ Within this framework however, numerous factors have been considered - relationships with others, economic and financial security, satisfaction with living conditions, coping ability, personal fulfilment, spirituality and so on.

Among 'quality of life professionals' - those

developing measures and conducting outcomes research - there is, therefore, considerable debate about what quality of life means in the context of illness. On the other hand, relatively little is known about how health care professionals define quality of life, use measures, or think about the utility of such assessments.

OLDER PEOPLE'S VIEWS

Similarly, little is known about how older people perceive what makes for life quality. One study reports that the term 'quality of life' was interpreted by older people to include both positive and negative features.⁹ Specific constituents of quality of life were not limited to health: indeed family was identified most frequently by respondents as the thing that gave their lives quality. Other aspects reported included activities, other social contacts and material circumstances. Specifically in the area of stroke research, patients have seldom been asked to identify what quality of life means. A Norwegian interview study reported that some patients were not familiar with the term quality of life, and it had to be paraphrased although it is not clear how it was explained. Others familiar with the term thought it referred to life style factors. The authors comment that this differs from the perspective of health professionals and researchers. The study concludes that the interviewees' view that stroke reduces quality of life was not directly related to their health status but to their evaluation of the changes caused by stroke.¹⁰

Our study is investigating the ways in which the concept is being used by stroke professionals and how this compares with stroke survivors' views on what quality of

life means. In interviews with doctors, nurses, rehabilitation therapists and others we found great diversity of definitions of quality of life, with many acknowledging that it is difficult to define and some saying that because it is subjective it *cannot* be measured. Some suggested that quality of life automatically declines with ageing, relating this to reduced expectations and increased infirmity. Some expressed cynicism about explicit use of the concept, seeing it as a challenge to their professional autonomy, an instrument of discriminatory rationing, or little more than a current fad. One consultant said:

I've been a consultant for twenty years. I don't think that during that time people have not cared about quality of life. It's just that there's a lot more jargon around it now... if you have to... say, 'Oh I must improve the quality of his life' then you're bloody useless to the patient.

Together with other work, including interviews with stroke survivors, one of the questions we will consider is how well the concept of quality of life, however defined, helps ameliorate the suffering of people who survive stroke. ■

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Defining Quality of Life Among Frail Older People

Susan Tester, Gill Hubbard and Murna Downs

The main aim of our project, *Exploring perceptions of quality of life of frail older people during and after their transition to institutional care*, is to contribute to understanding of the meaning of quality of life for frail older people. By 'frail older people' we mean older people with severe physical and/or mental illnesses or disabilities during the period of the 'fourth age' at the end of life. This period is perceived negatively in western societies. Our research will develop a new conceptualisation of frail older age by focusing on quality of life of frail older people in institutional care, whose perceptions have received little research attention.

QUALITY OF FRAIL PEOPLE'S LIVES

The definition and measurement of quality of life (QoL) have been widely discussed; however, where frail older people are concerned, the results of such work remain unsatisfactory, both theoretically and methodologically.¹ Since QoL studies of older people have tended to concentrate on health, the focus of such research is more appropriately termed 'health-related quality of life'.^{2,3,4} There is little empirical research based on a multi-dimensional concept of QoL and on definitions by older people rather than professionals. However, there have been recent attempts to use a broader conceptualisation of QoL including social, psychological, emotional, cultural, spiritual and environmental dimensions.^{5,6}

There is a lack of consensus in the conceptualisation and measurement of quality of life. The concepts found within this field are often ill-defined and used inter-changeably. Definitions of QoL will, to a certain extent, reflect the personal orientation of the researcher. Even if agreement is reached on the selection of key domains such as autonomy, privacy, esteem and choice, these are open to a variety of interpretations amongst and between researchers,⁷ professional care givers,⁸ 'experts',⁹ and older people.¹⁰ Older people's perceptions of QoL are likely to vary by age, gender, social class, marital status, personality, cognitive functioning, mental state and health status.^{3,4,11} Thus, it is doubtful that a generic definition of quality of life will be useful for all research purposes. Instead, QoL models specific to particular groups of older people are being developed, for example, dementia-specific quality of life models.¹²

Our research takes a qualitative approach to explore frail older people's own definitions and subjective experiences of QoL, focusing on differences and inequalities by social class, gender and ethnicity. Existing work

on the perspectives of older people or those with learning difficulties or dementia has tended to exclude people with the most severe disabilities and with whom communication is most difficult.^{3,13} We have stressed elsewhere the importance of verbal and non-verbal communication, and of recognising emotion as a dimension of QoL.¹⁴ We aim to develop innovative methods of eliciting views of frail older people, so that those with communication or other difficulties can be included, with the aid of *Talking Mats*, a tool developed by the Alternative and Augmentative Communication research team, University of Stirling.¹⁵

INVESTIGATING FRAIL OLD AGE

The project takes a broad approach to quality of life, discussing positive and negative aspects of frail older age with older people. First, we held six focus groups with older people and carers in the community, asking them to describe what life is like for frail older people, and particularly their perceptions of life in nursing homes. Second, we used the themes emerging from the focus groups as a framework for observation in nursing homes, carried out over 24 hours in each setting. Through the focus groups and observations we identified four key issues perceived as most relevant to the quality of life of frail older people in care homes: individual residents' activities; their relationships and interactions with other residents, staff and visitors; maintaining the individual's identity and autonomy; and the physical environment of the home. These themes and related sub-themes will form the framework for guided conversations and individual observations with a sample of 60 care home residents. The aim of these conversations is to explore the ways in which older people themselves interpret their situation and make sense of their daily experiences. The researchers will introduce the themes but will encourage the older people to develop new concepts and sub-

themes as they explore in depth their perceptions of life in frail older age and the aspects which contribute to a good quality of life.

Through in-depth ethnographic fieldwork the project will develop new understandings of QoL and of the factors which influence QoL. Although the focus of this study is the concept of quality of life, we recognise that quality of care may contribute to QoL. The understandings gained on QoL will be applied to the social policy issues of quality of care and empowerment of people in institutional care. Understanding variations in concepts and experiences of QoL for different social groups of frail older people will help in planning effective and appropriate services and contribute to reducing inequalities in experience of QoL. ■

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Project Updates

Brief updates to keep readers informed about the progress of GO projects

DEFINING AND MEASURING QUALITY OF LIFE

Coping with Life and Using Services: How People Over 75 Maintain Their Dignity and Self-esteem when Faced with a Limiting Physical Condition (John Baldock) Thirty five older people were interviewed on two occasions six months apart. Interviews completed in December 2000. Currently analysing the interviews in order to explore the relationship between identity, self-esteem, quality of life and service use.

Quality of Life of Healthy Older People: Residential Settings and Social Comparison Processes (Graham Beaumont) Data collection for Phase I proceeding on almost the original schedule; about 120 selection and main interviews now completed. Phase I ends and II begins about Easter 2001, when preliminary analysis of Phase I will also begin.

Adding Quality to Quantity: Older People's Views on Their Quality of Life and Its Enhancement (Ann Bowling) Waves 1-3 of the four Office of National Statistics survey data collection waves completed; wave 1 analysed. Two papers drafted. Qualitative data collection and analysis in progress.

Spiritual Beliefs and Existential Meaning in Later Life: The Experience of Older Bereaved Spouses (Peter Coleman) First interviews completed in July; six month follow-up interviews almost completed; one year follow-ups begin in April; analysis of typology of belief systems commencing in February.

An Anthropological Investigation of Lay and Professional Meanings of Quality of Life (Chris McKeivitt) Ethnographic fieldwork and interviews with professionals are now complete and data analysis is underway. The survey of elderly care physicians, physiotherapists and occupational therapists in England and Wales is also complete. Data is currently being entered for analysis. Thirty three interviews with stroke patients have been conducted and recruitment is on-going.

Environment and Identity in Later Life: A Cross-Setting Study (Sheila Peace) Focus group phase at an end; schedule due for piloting; interview phase forthcoming.

INEQUALITIES IN QUALITY OF LIFE

Influences on Quality of Life in Early Old Age (David Blane) Postal survey and data entry complete (November 2000). Analyses in progress. One paper submitted.

Inequalities in Quality of Life Among People Aged 75 and Over Living in the Community (Elizabeth Breeze) Data editing delayed by errors in scanning in data from forms. Re-scanning has to be done for several hundred questionnaires. Analysis therefore also delayed but hoping to be able to produce report by end April 2001.

Exploring Perceptions of Quality of Life of Frail Older People During and After the Transition to Institutional Care (Susan Tester) Focus groups completed and analysed, summary of findings available (December 2000). Observation in care homes in progress; currently designing tools for main fieldwork, guided conversations and informal observation with sample of frail older residents in care homes.

Ethnic Inequalities in Quality of Life at Older Ages: Subjective and objective Components (James Nazroo) Qualitative pilot was completed early this year, and the main phase of qualitative fieldwork has just (March 2001) begun.

Older People in Deprived Neighbourhoods: Social Exclusion and Quality of Life in Old Age (Thomas Scharf) Following development and piloting of a questionnaire that addresses issues relating to social exclusion, poverty and quality of life, the first major stage of fieldwork will take place in Spring 2001. This involves face-to-face interviews with 600 people aged 60 and over living in socially deprived areas of Liverpool, Manchester and East London. The project has produced two working papers (available on request) and an article in the journal *Education and Ageing*.

TECHNOLOGY AND THE BUILT ENVIRONMENT

Transport and Ageing: Extending Quality of Life for Older People via Public and Private Transport (Mary Gilhooly) Transport and Ageing data collection from the focus groups, street surveys and postal survey are complete. Interviews are currently being held with key professionals and policy makers. Face-to-face interviews with older people are currently being conducted in London and Paisley for the 'quota sample' study which is due to be completed at the end of September 2001.

HEALTH AND PRODUCTIVE AGEING

Quality of Life and Real Life Cognitive Functioning (Mary Gilhooly) Extensive piloting involving focus groups and face-to-face interviews for this project took up the first year of this two year project. Assessment of cognitive functioning amongst a sample of elderly people from the original MIDSPAN study is currently ongoing. Piloting for the study on lay concepts of cognitive functioning in old age is complete and structured interviews are about to start.

Evaluating the Impact of Reminiscence on the Quality of Life of Older People (Kevin McKee) Conducting fieldwork (three phases, first phase due for completion March 2001). Data entry ongoing. Two 'work in progress' presentations (September 2000, March 2001).

Older People's Experiences of Paid Employment: Participation and Quality of Life (Ivan Robertson) 1150 questionnaires have been returned, attempts are underway to access more non-workers below retirement age. 74 interviews, incorporating cognitive ability and personality assessment have been completed. Questionnaire data is currently being analysed.

FAMILY AND SUPPORT NETWORKS

Older Men: Their Social World and Healthy Lifestyles (Sara Arber) First part of the qualitative component of the project: observations in social clubs and organisations, and interviews with managers/secretaries, is virtually complete. Analysis in progress. Second part of the qualitative component of the project: 100 interviews with men over the age of 65 stratified for age and marital status is over one-third completed. Transcription and preliminary analysis in progress. Papers presented at three national and one international conference.

Older Widow(er)s: Bereavement and Gender Effects on Lifestyle and Participation (Kate Bennett) Female sample recruited, interviewing almost complete; male sample recruitment and interviewing underway; preliminary analysis commencing; methodological paper in progress.

Grandparenthood: Its Meaning and Contribution to Older People's Lives (Lynda Clarke) Stage 1 fieldwork completed January 2000. Stage 2 fieldwork started June 2000 and will be completed February 2001. Currently writing up results from first survey and transcribing final data from second survey. Five conference presentations and three papers in preparation.

Family, Work and Quality of Life: Changing Economic and Social Roles (Maria Evandrou) The project team is analysing the caring and work history information in the Family and Working Lives Survey (1994/5). Initial findings have been presented at the BSG and BSGS annual conferences.

Quality of Life and Social Support Among Older People From Different Ethnic Groups (Mike Fisher) So far this project has identified systematically the issues in data collection on social networks, and designed new approaches in order to elicit respondent definitions. We have also opened the way for secondary access to the Family Resource Survey. We have identified a team of interviewers, for whom training is taking place. Pre-pilot and pilot work will begin shortly thereafter, and full fieldwork by the beginning of March.

Loneliness, Social Isolation and Living Alone in Later Life (Christina Victor) Completed three-quarters of the quantitative fieldwork and about half of qualitative fieldwork. Just completed the first batch of transcriptions. Two papers from pilot study currently under review by journals.

PARTICIPATION AND ACTIVITY

Empowerment and disempowerment: comparative study of Afro-Caribbean, Asian and White British women in their third age (Mary Maynard) So far 130 women have participated in the research, either in focus groups or one-to-one interviews. The interviews have been carried out with Bangladeshi, Pakistani and Indian women, as well as with different African-Caribbean women. Interviews with white British women have included those from the Polish community. Analysis of the data is an ongoing part of the project and a synopsis of preliminary findings is in preparation.

Older Women's Lives and Voices: Participation and Policy in Sheffield (Lorna Warren) First phase of field work (discussion groups) completed in late January 2001. Training of volunteer interviewers for second phase in progress. Analysis of discussion groups has also commenced. Videoring of project progressing smoothly.

Older People and Lifelong Learning: Choices and Experiences (Alexandra Withnall) Ten focus group discussions completed December 2000. Construction of conceptual model completed. Three papers discussing the background to the research are available.