

Quality of life, Happiness and Satisfaction with Life of Individuals 75 Years Old or Older Cared for by a Home Health Care Program

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This case study identifies the elements that compose the Quality of Life (QoL) of individuals who were 75 years old or older and receive care at home. The study's sample was composed of individuals 75 years or older cared for by a home health care service in the primary health care unit in Vilafranca del Penedès, Spain (n=26). The variables included: a) socio-demographic data; b) concept of QoL; c) perception of QoL; d) reasons for their perception; e) satisfaction with life and related aspects; and f) feeling of happiness. Face to face interviews were conducted. A total of 76.9% of the individuals reported a good perception of QoL and the main reasons related to it were: health, family and social relationships, and the ability to adapt. Role Theory and Disengagement Theory explain the adaptation process of these individuals at this point in life.

Descriptors: Adaptation; Home Care Services; Quality Of Life; Happiness; Aged; Personal Satisfaction.

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Qualidade de vida, felicidade e satisfação com a vida em anciãos com 75 anos ou mais, atendidos num programa de atenção domiciliária

Objetivou-se detectar os elementos que participam da qualidade de vida (QV) das pessoas com 75 anos, ou mais que recebem cuidados domiciliários. O desenho foi de estudo de caso. A amostra do estudo foi configurada por pessoas com 75 anos, ou mais, atendidas pelo serviço de Atendimento Domiciliário da Área Básica de Vilafranca del Penedès (n=26). As variáveis foram: a) dados sociodemográficos, b) conceito de QV, c) percepção de QV, d) motivos, e) satisfação com a vida e aspectos relacionados e f) sentimento de felicidade. Aplicou-se a técnica da entrevista frente a frente. Do total, 76,9% apresentou boa percepção de QV e os principais elementos relacionados foram: saúde, relações familiares e sociais e adaptação. A teoria dos papéis e a teoria da desvinculação explicam o processo de adaptação desses indivíduos, nessa etapa da vida.

Descritores: Adaptação; Serviços de Assistência Domiciliar; Qualidade de Vida; Felicidade; Idoso; Satisfação Pessoal.

Calidad de vida, felicidad y satisfacción con la vida en personas ancianas de 75 años atendidas en un programa de atención domiciliaria

Se objetivó detectar los elementos que participan en la Calidad de Vida (CV) de las personas mayores de 75 años que reciben cuidados domiciliarios. El diseño fue de un estudio de caso. La muestra del estudio la configuraron las personas con 75 años o más, atendidos por el servicio de Atención Domiciliaria del Área Básica de Vilafranca del Penedès (n=26). Las variables fueron: a) datos socio demográficos, b) concepto de CV; c) percepción de CV, d) motivos; e) satisfacción con la vida y aspectos relacionados; f) sentimiento de felicidad. Se aplicó la técnica de la entrevista cara a cara. El 76,9% presentó una buena percepción de CV y los principales elementos relacionados fueron la salud, las relaciones familiares y sociales y la adaptación. La teoría de los roles y la teoría de la desvinculación explican el proceso de adaptación de estos individuos en esa etapa de la vida.

Descriptorios: Adaptación; Servicios de Atención de Salud a Domicilio; Calidad de Vida; Felicidad; Anciano; Satisfacción Personal.

Introduction

The concept of QoL has evolved in recent years since the time of its basically materialist conception, in which priority was given to objective aspects of life, having currently moved to a perspective in which subjective aspects are considered essential. These conceptions imply a rationale that questions whether QoL should refer only to what the subject determines to be elements intervening in her/his "quality of life" or whether one can establish a general concept of QoL that can be applied to all individuals. There

is currently an agreement that this construct has a multidimensional character and both objective and subjective components are identified⁽¹⁻²⁾. This definition is even more complex if one attempts to conceptualize the QoL of elderly individuals. The aging of the population in recent years has fomented interest in and raised concern for the QoL of elderly individuals; the number of studies addressing this collective has increased⁽³⁻⁴⁾. In general, certain characteristics, both negative and positive ones, are attributed to elderly

individuals, though negative characteristics seem to be more relevant, a fact that contributes to older individuals not feeling useful in society⁽⁵⁾. Some of the studies addressing QofL in old age indicate diverse factors that elderly individuals consider important in life: health, autonomy, psychological factors (loneliness, personality, feelings of worthlessness that affect one's perception of wellbeing), appropriate environment (housing, social environment, services), social factors (social isolation), self-esteem and dignity, as well as economic deprivation^(2,6). Nevertheless, older individuals' perception of QofL is not entirely bad, and many appear fairly happy and satisfied with their current life^(2,4,7).

Some authors consider the experience of high levels of subjective wellbeing "happiness". Hence, we understand that an individual has a high level of subjective wellbeing when s/he is satisfied with life and lives in a positive manner. On the other hand, someone with a low level of subjective wellbeing is dissatisfied with life and experiences negative emotions such as anxiety and/or depression⁽⁸⁾. The truth is that as individuals age, the onset of chronic diseases is expected, as well as the existence of fewer social networks, so that the strategies used at this point in life to cope with such diseases may either contribute to or worsen one's perception of QofL in old age. From this perspective, QofL can be classified within Role Theory⁽⁹⁾ from the standpoint of sociology, which holds that the ability of elderly individuals to adapt to their situation and social position is related to the perception of happiness and QofL. Individuals behave, in relation to themselves, according to predictable and coherent schemes, which are called social roles. Hence, older individuals assume a dependent role, acknowledging what it implies in the society to which s/he belongs. Disengagement Theory is among the social theories of aging⁽¹⁰⁾. This theory holds that elderly individuals gradually withdraw from social life and view society as offering fewer and fewer possibilities. It also asserts that as people draw nearer to the end of life, the greater is the distance between older individuals and society. This study's hypothesis is based on the idea that, depending on how well one adapts to her/his elderly role and to

the role of a chronically ill individual, one encourages having a correct or good perception of her/his QofL. The individual may realize that given her/his age and disease, s/he is not actually in so bad a situation and consequently does not place much weight on necessary and relevant aspects such as social relationships. Nursing professionals from home health care services can identify the needs of elderly individuals and provide the required care at the individual's home. Based on this hypothesis, this study examines the elements composing the QofL of individuals 75 years old or older who are cared for by a home health care service.

Method

This is a case study and the theoretical framework on which it is based includes Role Theory and Disengagement Theory. The analyzed case was a home health care program implemented in the primary health care area of *Vilafranca do Penedés*, Spain. The study's population was composed of individuals who are 75 or older cared for by the home service. This age range was chosen because it is more dependent and presents more care needs. The highest health agency in the Autonomous Community of Catalonia, the Health Catalonia Institute, gave permission to the primary health care center in *l'Alt Penedès* to contact the individuals in the sample and conduct the study. No permission was asked of the Research Ethics Committees at the Health Center or the Health Catalonia Institute because no clinical trials or interventions were conducted.

First, the establishment of the study's sample took into account the distribution of the population of individuals who are 75 or older living in *Vilafranca do Penedés*. Then, 10% of the total population was selected from the home care service's database aiming to keep the service's base structure as much as possible and obtain representation from all the strata (by age and gender), keeping proportions equivalent to those of the population cared for by the service in *Vilafranca do Penedés* (Table 1). This classification is similar to the distribution of the population of *Vilafranca*, though it is not a representative sample and the results cannot be generalized.

Table 1 – Population of individuals who are 75 or older from the database of the service in *Vilafranca do Penedès*, Spain – 2006 (absolute and relative values)

Population of dependent individuals from the service's list						
Age	Absolute values			Relative values %		
	Men	Women	Total	Men	Women	Total
75-79	29	36	65	11.9	14.8	26.7
80-84	19	43	62	7.8	17.6	25.4
85-89	23	34	57	9.4	13.9	23.3
90-94	18	23	41	7.4	9.4	16.8
95 years or older	5	14	19	2.0	5.7	7.7
75 years or older	94	150	244	38.5	61.5	100

Sample of individuals to be interviewed						
Age	Absolute values			Relative values %		
	Men	Women	Total	Men	Women	Total
75-79	4	4	8	15.3	15.3	30.6
80-84	2	4	6	7.6	15.3	22.9
85-89	2	4	6	7.6	15.3	22.9
90-94	1	2	3	3.8	7.6	11.4
95 years or older	1	2	3	3.8	7.6	11.4
75 years or older	10	16	26	38.5	61.5	100

Inclusion criteria were: living in the city of *Vilafranca do Penedès*, being 75 years old or older and being included in the home health care program. The selection of sampling units was based on the service's list and performed according to systematic sampling criteria, randomly selecting individuals to be interviewed, separating men and women. A larger number of women were interviewed to maintain the same proportion found in the total database of the service. The studied variables were: a) socio-demographic data; b) definition of QoFL; c) perception of QoFL; d) reasons that led to current perception; e) satisfaction with current life and related

aspects; f) feeling of happiness. Personal interviews (face to face) were held in the elderly individuals' homes and recorded with their consent. The interviews were performed after a phone call based on data provided by the nurses of the services. The instrument used was a questionnaire addressing socio-demographic information, four open questions and three questions utilizing a Likert scale. Questions validated by the Sociological Investigation Center⁽⁷⁾ and the World health Organization⁽¹¹⁾ were used to develop the instrument (Figure 1). A pilot test was conducted before interviews were initiated with 26 the individuals.

Questions	Items
Socio-demographic data	Gender, age, marital status, family situation, type of income, level of education
How do you define 'quality of life'?	-
How do you evaluate your current quality of life?	1.Very Good 2.Good 3.Regular 4.Poor 5.Very Poor
What are the reasons for your perception of your quality of life?	-
What is your current level of satisfaction with your life?	1.Very satisfied 2.Fairly satisfied 3.Fairly dissatisfied 4.Very dissatisfied 5.Did not answer
Related aspects	-
In relation to the feeling of happiness: how do you consider your current situation?	1.Very happy 2.Fairly happy 3.not very happy 4.Not happy at all 5.Did not answer
What aspects generate more satisfaction at the moment?	-

Figure 1- Instrument used

Interviews took approximately 30 minutes per individual. The criterion of triangulation was also applied at the time of data collection to reduce any potential bias of a single interviewer. Interviews were carried out in 2007*. Data were analyzed according to content analysis and were grouped in categories when there were qualitative questions.

Results

There were a total of 26 individuals 75 years of age or older with an average age of 84.5 years old (standard deviation = 6.1). Women totaled 61.5% of the sample, which is explained by the fact that women have a longer life expectancy and are more prone to have chronic diseases during old age. These results are comparable to the elderly population of *Vilafranca do Penedès* and other Catalanian and Spanish populations, where women of advanced age require informal care. In relation to marital status: 46.2% were married, 38.5% were widowed and 15.3% were single. Independent elderly individuals lived by themselves while dependent individuals lived with their closest family members. In relation to offspring, 84.6% of the interviewed individuals had children, which helps to avoid loneliness and a lack of care provided for dependent older individuals. Income in retirement varied between 300 and 600 Euros/mo. The level of education was low; more than half had no education.

Individuals older than 75 years of age had difficulty defining 'quality of life' and part of their difficulty was due to the complicated definition of the construct itself. Health status is considered to be a necessary element for QoL, according to the answers provided by the interviewees. Some individuals stress health status as the only element while others include other concepts such as autonomy, having company, being helped in everyday life, being able to adapt to the current context or having money and love. Elderly individuals frequently hold health to be the only element composing QoL. *Being healthy is the most important thing* (E.01, E.06, E.15, E.16, E.17, E.18). Other elderly individuals reported that though health is an important element influencing QoL, it is not the only one and define it together with other concepts such as: having company, money or help, as demonstrated in the following excerpts. *It's hard to tell - perhaps the best would be to have more money (for*

arrangements, clothes) but health, health is the main thing (E.03). *Being healthy and having autonomy* (E.09, E.10). *Being healthy and able to walk* (E.08). *Being healthy and having money* (E.12). *Being healthy and able to adapt* (E.20). *Being healthy and having company* (E.21, E.24). *Being healthy and having help* (E.23). *Being younger than 50 years old, being younger and able to work* (laugh), *I'd like to drive a garbage truck. That the family is healthy* (E.13). *Having company, not being alone* (E.02). Another element highlighted by the interviewees was love, affection and feeling loved. Although some definitions incorporate, as the song goes, *health, money and love* (E.05, E.19), others also highlighted the following definitions of *having love* (E.26). *Having love, affection and good relationships, only* (E.22). Family relationships are another element stressed by the elderly individuals, as well as getting along with the family, which is reflected in answers such as: *having a good life at home* (E.04). *Good relations with the family* (E.14). *Self-realization, because I wanted to be a singer but wasn't allowed to, and having good relationships* (E.11).

The ability to adapt is very important for the achievement of wellbeing. One should take into account that deterioration is part of the aging process and adapting to new limitations requires great effort. Acknowledging one's role as an elderly individual facilitates adaptation. It is important to these individuals to adapt and conform to their current situation, as observed in the following statement: *to conform* (E.07). *Being healthy and adapt* (E.20).

Social life is necessary for one to feel well and avoid isolation, as observed in the following report in which the older individual wants to have a social life, go out and take part in leisure activities. *I don't know, my life is dull, I go from work to home. There've been years I don't go out, don't go to the movies, I'm always at home.* (E.25). Autonomy and independency are indicated as elements necessary to the perception of an appropriate QoL, though adaptation, material and emotional help also influence it. The individuals also mentioned other elements necessary for having good QoL: having good social relationships, having company, feeling loved, and maintaining good relationships. Most of the individuals older than 75 years of age reported good QoL; only two individuals reported poor QoL (Table 2).

It is worth noting that none of the individuals reported poor relationships with family members; they either omitted this information or it is not polite to inform

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such type of problems. A possible relation between not having social relationships and the perception of a lower QoFL was observed. Even though the elderly individuals acknowledged they could not leave home given their age and limitations, they reported the desire to maintain relationships with people their age. When the perception of QoFL was related to health status, only two individual out of the 14 who reported a regular health status, perceived their QoFL as regular. This seems to indicate that health is not the only element determining the interviewees' perceptions of QoFL.

Table 2 – Perception of quality of life of dependent elderly individuals

Perception	% (N=26)
Good	76.9
Poor	7.7
Regular	15.4
Total	100

Source: Extracted from the study Care and Quality of Life in Vila Franca do Penedès, 2007

The reasons the elderly individuals reported when questioned why they positively or negatively evaluated their QoFL were diverse. The most frequent answers related to a positive perception of QoFL mainly referred to the ability to adapt to the situation. These individuals felt they could not expect anything else from life given their age and diseases, seeming to confirm the relationship between acknowledging the role of 'ill and elderly individual' and their perception concerning QoFL. Having more resources, health, love, autonomy and being supported by family members are also important and these are mentioned in the following excerpts.

Being adapted to the current situation: *Good, I managed to adapt to the fact I cannot walk anymore, cannot use the stairs* (E.07). *Good, because I adapted myself to the needs* (E.08). *Good, I'm in a good shape considering my age and I'm well cared for* (E.12). *Good, I'm well given my age, couldn't ask for more* (E.13). *Good, I'm adapted to the situation; I read a lot* (E.16). *Good, because I'm fairly healthy for my age, have some money and love* (E.19). *Good, you have to adapt to the circumstances, yes I believe so* (E.26).

Having resources appropriate to your needs: *Good, because I don't lack anything, people help me* (E.04). *Good because, I don't lack anything, I have resources and health, I can buy whatever I want* (E.05). *Good, because I have everything I want, though I'm not very healthy* (E.11). *Good, I don't lack anything* (E.14). *Good, because I don't lack*

anything, I have everything I need, the truth is that I'd like to be able to walk (E.20).

Being fairly healthy and adapting to chronic diseases: *Good, because I'm healthy and have company* (E.02). *I feel well, it's good* (E.03). *Good, now yes, I was sick before but now I'm well, I was uneasy, scared* (E.15). *Good, now I'm well* (E.24).

Feeling loved and having family support: *Good, because I have love at home* (E01). *Good, because I'm supported by my children* (E.22). *Good, because I'm well cared for* (E.23).

Autonomy: *Good, because I can take care of myself* (E.10).

The elements related to poor or regular perception of QoFL were: loss of autonomy and health, loneliness and acceptance as observed in the following answers.

Loss of autonomy and health: *Regular and limited, I'd like to be able to do more things* (E.17). *Poor because my health is poor and I depend on others* (E.18). *Regular, I'm not well, neither good nor poor.* (E.25). *Poor, because I'm not healthy. I used to work, to go out more* (E.06).

Loneliness: *Regular, I feel alone, my wife doesn't recognize me (sadness)* (E.21).

Acceptance: *Regular, but I accept it, given my age* (E.09).

In relation to the variable that identifies satisfaction with one's current life, the results showed that 69.2% of the individuals were fairly satisfied; 15.4% were very satisfied; 15.4% fairly dissatisfied but none were very dissatisfied. The reasons reported by the elderly individuals who were very satisfied with their current lives were: *adaptation and affection received from their children*. Individuals who were fairly satisfied reported the following reasons: *adaptation, lack of health, self-realization, money, adaptation and resignation*. The reasons reported by individuals who were fairly dissatisfied were: *not being healthy, resignation and sadness*.

The elderly individuals' most frequent answer concerning their perception of happiness was 'fairly happy' (57.7%), while 11.5% were very happy and 30.8% were not very happy. The reasons of some of the individuals who reported being fairly happy included being content with their children, having a healthy family, and having adapted to their circumstances. Lack of happiness was associated with the loss of family members, having an unhealthy family, lacking resources or not being able to visit family members living far away. In relation to the variables that determine the most satisfactory aspects in the life of an elderly individual, the results show: being with family, having company, being at home and/or going out, feeling well cared for and also doing

nothing special. Some of the answers indicate the family is one of the aspects from which individuals derive more satisfaction.

Discussion

Among the definitions and perceptions of QofL reported by the individuals, being healthy is one of the most frequently reported; various studies highlight the importance of health in the valorization of QofL^(7,12-14).

Being healthy, however, is not the only element considered. Good relationships, the ability to adapt, feeling loved and supported by family, having money, receiving help and having resources and a social life are also valued. According to the study by the *Viure i Conviure* Foundation⁽⁴⁾, possessing economic ability, good socio-family relationships and good health were the three most important factors supporting a positive QofL in the studied older individuals. This same study also reports that individuals living in Barcelona and other central regions such as *l'Alt Penedès*, have a better perception of QofL compared to populations living in *Camp de Tarragona* and in *Tierras de l'Ebre*; elderly individuals living in *l'Alt Penedès*, Catalonia are those who have the best perception of QofL. The five dimensions most reported by elderly individuals in another study⁽⁶⁾ addressing QofL were: health, family, economic status, social networks, leisure activities and free time. This study's results agree with those found in the previously mentioned studies because it relates QofL to a positive perspective such as having good health and good family relations, while a negative perspective is related to poor health.

Another study conducted in five countries in the European Union observed that results concerning the concept of QofL and its evaluation were similar in the five countries (Germany, Italy, Netherlands, the United Kingdom and Sweden), with a partial exception in Italy. Differences related to living conditions were "objective and subjective," as was the importance of health and subjective wellbeing for QofL. Most of the population studied in the Netherlands was satisfied with life, though this proportion diminished with age. The results found in Germany were contradictory. Some individuals reported that QofL increased with age while others indicated the opposite. Results from the United Kingdom also showed high levels of satisfaction among older individuals. Family relations in Italy represented the most important element for older individuals. In Sweden, the importance of biographical analysis to show the meaning of old age

in relation to one's remaining life was observed, on one hand. On the other hand, the level of satisfaction was related to subjective health, social relationships, participating in pleasurable activities, and having an extroverted and stable personality. Personality appears as the main determinant of wellbeing⁽¹⁵⁻¹⁷⁾.

Another study carried out in the Midwest of Brazil observed that in addition to health, support, relationships, and living with family, there are elements that worry elderly individuals⁽¹⁸⁾. When the elderly individuals were asked how they classified their current QofL, adaptation to their current situation played a very important role in their answers. Hence, the individuals' ability to adapt to their circumstances and to the social role they play in society are important elements to be taken into account when evaluating satisfaction with life and the QofL of elderly individuals. Therefore, Role Theory and Disengagement Theory partially explain the results. Other authors also relate the ability to adapt to good perception of QofL. Replacing some objectives by other more realistic ones helps individuals to have better control of the situation⁽¹⁹⁻²¹⁾.

This study's results indicate that women (87%) have a better perception of QofL than men (60%), though the larger number of women in the sample may have produced some bias in the results. The results of another study show the opposite, that is, men were those reporting a better perception of QofL⁽⁶⁾. In relation to the individuals' perception of happiness, a considerable share of individuals reported being quite happy and attributed it to the fact that they were content with their children, their family's health and having the ability to adapt to their circumstances and age. In general, the interviewed individuals were fairly satisfied with their current lives and with their family life, though they would like to be more autonomous. Such results have also been found in other studies^(6,10,17).

Identifying the needs of elderly individuals, the support they require, and satisfaction they have in relation to their lives and environment in which they live is useful for health services, professionals, and those making public policies to heed the needs of this age group⁽²²⁾.

Final considerations

Nursing professionals can identify the needs of elderly individuals for whom they provide care if they take into account that the needs of this collective are often either not identified or not valued due to the view that certain situations are normal in old age.

The study's sample is small and its results cannot be generalized to the entire population of individuals 75 years or older, or to those living in *Vilafranca do Penedès*, Spain. However, its value lies on the characteristics of the sample and also in the in-depth analysis performed on the studied topic. Hence, we expect that future studies will address the mechanisms and the level of individuals' ability to adapt to new social contexts. The dimensions influencing these individuals' perception of QoL need to be investigated in order to understand what needs affect the level of satisfaction elderly people experience in their lives, especially in the case of those who are dependent on others. Among these aspects, evaluating how the lives of these people can be improved is also needed. Even though they do not complain about company or social life, they acknowledge their desire to relate with people their age.

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