

3-2002

# Quality of Life and Aging: Exploring the "Paradox of Well-Being"

Regula H. Robnett

University of New England, rrobbett@une.edu

Follow this and additional works at: [http://dune.une.edu/ot\\_facpubs](http://dune.une.edu/ot_facpubs)



Part of the [Occupational Therapy Commons](#)

---

## Recommended Citation

Robnett, Regula H., "Quality of Life and Aging: Exploring the "Paradox of Well-Being"" (2002). *Occupational Therapy Faculty Publications*. Paper 9.

[http://dune.une.edu/ot\\_facpubs/9](http://dune.une.edu/ot_facpubs/9)

This Article is brought to you for free and open access by the Occupational Therapy Department at DUNE: DigitalUNE. It has been accepted for inclusion in Occupational Therapy Faculty Publications by an authorized administrator of DUNE: DigitalUNE. For more information, please contact [bkenyon@une.edu](mailto:bkenyon@une.edu).

---

# GERONTOLOGY

SPECIAL INTEREST SECTION QUARTERLY

---

Volume 25, Number 1 • March 2002

Published by the American Occupational Therapy Association, Inc.

---

## Quality of Life and Aging: Exploring the "Paradox of Well-Being"

■ Regi Robnett, MS, OTR/L, BCN

During the past 50 years, quality of life is a construct that many researchers have studied. Occupational therapists and occupational therapy assistants often claim to improve the quality of their clients' lives. Making note of references to quality of life in the occupational therapy literature, one could garner a list of hundreds of articles. However, in the occupational therapy context, the term *quality of life* rarely is defined. The words *quality* and *life* are easy enough to discern, but the meanings behind the words seem to vary with author. Sometimes, quality of life has been described in vague terms, such as *well-being*, or as the lack of something, such as the absence of disease or pain. In occupational therapy, quality-of-life improvements sometimes are equated to improvements in self-care or other functional skills. When working with older adults, the concept of quality of life becomes particularly problematic because society tends to promote the idea that quality of life decreases with age because people "suffer" from the consequences of aging. It is hoped that this article provides occupational therapists and occupational therapy assistants with information that refutes these common societal perceptions and will assist practitioners in designing interventions that are even more data meaningful and more client centered.

### The Roots of the Quality-of-Life Discussion

Historically, discussion about quality of life has been the domain of philosophers who typically have immersed themselves in debating about the qualities that constitute a good or meaningful life. For example, Aristotle wrote that the achievement of happiness was the ultimate goal of life but that the state was not one of pleasure, but one based on meaningful activity of the mind. More than 50 years ago, scientists began to show an interest in quantifying the illusive construct of quality of life. Early in the research process, the level of life quality was viewed as being influenced primarily by demographic factors, such as income level, marital status, and health. Assumptions were made that healthy and wealthy people had a higher quality of life than people who were poor and sick, although research found this to be only partially true. When demographic variables were considered all together, they accounted for, at best, 50% of the variance of quality of life or life satisfaction (Larson, 1978). Researchers in gerontology also have studied the impact of gender, educational level, race, employment status, marital status, transportation, residence, activity level, social interaction, and age. Outcomes demonstrated that with the exclusion of social activity, these factors generally explained only 1% or less of the variance in general quality-of-life scores.

Often, the medical literature has focused on life quality, and Lawton (1991) specifically termed this *medical quality of life*. Because of the increases in the prevalence of chronic diseases, the sheer number and increasing proportion of older people, the technological advances used to keep people alive, and the consequential ethical

dilemmas that ensue, *quality* of life issues are fiercely debated along with *quantity* of life issues. Unfortunately, the current literature does not provide consistent definitions of medical quality of life or of a more general quality of life. Diseases and their symptoms and treatment problems seem to provide the source of many quality-of-life measures.

Pain level is one factor often considered in medical quality-of-life evaluation. Surprisingly perhaps to some readers, the prevalence of pain does not vary significantly across age groups, even though pain-associated illnesses increase with age, and pain is associated with lower perceived quality-of-life scores. Little conclusive evidence suggests that older adults have a different pain experience than younger people (Lawton, 1996).

Lawton (1991), one of the leading researchers in this subject, believed that quality-of-life measures should include self-evaluation of competence in the roles that we attempt to fulfill, activities of daily living, and cognition. Lawton advocated for an assessment that is multidimensional because life itself is multidimensional. Therefore, basing our evaluation of quality of life on just health or just pain levels or any one factor is not likely to yield comprehensive or holistic results.

Another vital source of information rarely mentioned by quality-of-life researchers is the study participant's subjective viewpoint of precisely which factors should be included in a quality-of-life measurement tool. For example, Lawton (1991) stated that perceived level of wellness or health is a subjective measure of quality of life. Few would argue that health is not an important component of quality of life; however, it is possible that an elderly person with a terminal illness would perceive his or her own health as poor and yet still maintain that he or she has a high quality of life because other factors are even more crucial to that person than health. Therefore, self-ratings of quality-of-life indicators are important, but subjective views on which indicators should be included in assessing an individual's quality-of-life measurement are crucial as well.

### The Paradox of Well-Being

Our ageist society still tends to uphold the view that quality of life declines with age. Society typically has narrowed down the construct of quality of life to a single score (based on inputs from one or many factors), and this measure is expected to decrease as age increases, just as people expect memory and physical fitness to deteriorate over time. People are expected to have a lower sense of subjective well-being and, therefore, less happiness as the years pass. In reviewing Larson's (1978) overview of the quality-of-life literature, the anticipated decrease in quality of life seems logical because older people often "suffer" age-associated disabilities and declining health, lose valued roles, become widowed, lose the ability or privilege to drive, and/or are forced sometimes to move to housing that is less desirable. One small, but momentous problem occurs with this belief system: Older

---

people tend to bulge out of these stereotypes about happiness regularly. Over the years, more studies have shown that socioeconomic factors influence subjective quality of life only to a very modest degree. They fall far short of explaining any major differences in happiness. Elderly people who have had numerous hardships and health setbacks are not less happy than middle-aged or younger people (Baites & Baltes as cited in Mroczek & Kolarz, 1998). This finding has been termed the *paradox of well-being* (Mroczek & Kolarz, 1998). Self-described well-being, *amazingly*, does not tend to decline with age and may even improve over time at *least* until 77 years of age (Carstensen, 1991, 1995; Lawton, 1996; Mroczek & Kolarz, 1998). These findings were the result of studies examining life satisfaction and affect.

Carstensen's (1991) socioemotional selectivity theory explains the changes in affect as related to quality of life as one ages. As expected, older people view their futures as more contained, whereas younger people have an almost unlimited or unbounded view of what lies ahead. What occurs, Carstensen maintains, is that this view of having only a limited time left in life causes older people to try to maximize the positive aspects of their lives while minimizing the negative. (This trait may be why we often hear clients telling us that they are "fine" or in good health even when they have a stockpile of dire conditions.) These attitudinal changes could be explained by increasing maturity (Labouvie-Vief & Blanchard-Fields as cited in Mroczek & Kolarz, 1998) or by an increased level of wisdom. People may be able to learn to be happier by appreciating the positive aspects of life while not ignoring but, rather, deemphasizing negative events (Lawton, 1991).

More recent theories of well-being hypothesize that one's personality largely determines one's sense of happiness or well-being. Many gerontic researchers (Mroczek & Kolarz, 1998) now believe that subjective well-being is affected largely by stable personality traits that may be genetic. This "set point perspective" (Mroczek & Kolarz, 1998, p. 1334) alleges that our disposition (particularly affect) has an extremely potent influence on happiness levels.

Several researchers have described the concept of self as important to one's perception of quality of life. Atchley (1991) reported that developmental changes occur to the self during normal aging. For example, aging by way of longevity tends to increase one's level of experience; therefore, elderly people are more likely to have a more robust self-concept. They also may be more realistic about themselves, be more likely to have positive self-esteem, and possess a higher level of self-acceptance. Whereas younger people more likely will describe themselves on the basis of physical appearance, social roles, and attributes, older people more likely will identify their own individual themes and life stories that reflect their values, with less concern given to what others might think. This more polished and mature sense of self also may have positive implications for improved subjective quality of life in spite of objective negative life events.

Supportive relationships are important predictors of psychological well-being. If one perceives him- or herself as being socially supported and socially engaged, he or she tends to report a higher level of health and well-being (Carstensen, 1991). However, declining rates of social contact do not necessarily translate into a decrease in per-

ceived social support. In fact, overall declining contact with others may relate to increasing levels of perceived social support because older people may maintain or increase their sense of social connectedness with loved ones and close friends. Carstensen (1991) maintained that the level of social connectedness attained through the social selection process best predicts life satisfaction. As people age, they may voluntarily give up meaningless or negative social interaction. In citing the Berlin Aging Study, Carstensen (1995) found that people in their nineties had significantly smaller social networks. However, the reductions in social contacts occurred more in peripheral than in primary relationships. The older people in the study had approximately the same number of "emotionally close social partners" (p. 151) as the younger people. Therefore, it behooves us not to jump to the conclusion that elderly people should be pitied because their social circle has contracted.

The frail or at-risk elderly population is described as "suffering from diminished abilities or limitations brought by injury, chronic physical or mental illness, or acute illness" (Gentile, 1991, pp. 75-76). As a society, we tend to pity these "poor" people. Several studies have measured the quality of life of residents in nursing homes because these persons represent the largest group of frail elders. Gentile (1991) reported that residents' quality of life depends on the quality of care, their level of satisfaction with life, feelings of self-worth, and self-esteem. She stated that the residents' quality of life can be improved by encouraging close relationships and by providing a home-like atmosphere and an environment that fosters independence, comfort, and as much control as possible over one's life situation.

Cohn and Sugar (1991) reported that most quality-of-life studies in long-term-care settings have focused on quality of care, a trend that has been restrictive and has ignored the psychosocial, cultural, and environmental factors involved in quality of life. Few studies have looked at the residents' own perceptions of quality of life. Cohn and Sugar completed a pivotal study that included the residents' perceptions of quality of life as well as included those of staff, aides, and family. Despite study weaknesses associated with lack of randomization, these researchers found some fascinating results: The majority of the residents (73%) viewed their lives as "contented, comfortable and meaningful." (Cohn & Sugar, 1991, pp. 35-36). Residents and the other participating groups were asked to define quality of life in the areas of morale, abilities, autonomy, social-emotional environment, physical environment, and care. Cohn and Sugar found that residents most frequently identified activities as contributing to quality of life, next mentioning the fulfillment of basic needs and, finally, quality of care. In sharp contrast, staff, aides, and family mentioned quality of care significantly more frequently. Aides, in particular, mentioned such care issues as residents having a shower twice a week, proper meals, activities available, and "a variety of things done for them" as important to quality of life.

Participants in Cohn and Sugar's (1991) study were asked about how their abilities affected their quality of life. Somewhat surprisingly, the residents themselves tended to rate physical health more often as not important, whereas the staff, aides, and family tended to view physical health as very important. All groups of participants identified contact with family as significant. Physical environment, often touted as important to level of quality of life, was rarely mentioned by any group. Family members thought that the residents missed the physical environment aspects of their previous lives the most. The residents, on the other hand, most often reported missing specific meaningful social activities. The researchers stated that a critical step in quality-of-life research, especially for frail elders, is to examine these intergroup differences in defining quality of life and then work together to accommodate the variations. As health care professionals, we must seek to have clients define what quality of life is to them so that we can work on improving their own quality of life rather than our conception of what it ought to be.

## Conclusion

As we have seen, the construct of quality-of-life issues with elderly people is explained partially by many factors, but an explanation universal proportions has eluded researchers to date. On examining the construct of quality of life in relation to the stereotypes related to aging, we have seen that the ageist beliefs often are more wrong than right; elderly people tend to be happier than they are expected to be

## GERONTOLOGY

SPECIAL INTEREST SECTION  
QUARTERLY

(ISSN 1093-717X)

**Chairperson:** Ellen L. Kolodner  
**Editor:** Pamela Toto  
**Managing Editor:** Barbara Scanlan

Published quarterly by The American Occupational Therapy Association, Inc., 4720 Montgomery Lane, Bethesda, MD 20814-3425; [ajot@ota.org](mailto:ajot@ota.org) (e-mail). Periodicals postage paid at Bethesda, MD. POSTMASTER: Send address changes to *Gerontology Special Interest Section Quarterly*, AOTA, PO Box 31220, Bethesda, MD 20824-1220. Copyright © 2002 by The American Occupational Therapy Association, Inc. Annual membership dues are \$187 for OTs, \$111 for OTAs, and \$53 for OT students. Special Interest Section (SIS) membership, including a subscription to the *SIS Quarterly*, for OTs and OTAs is \$25 for the first and \$16 for each additional. SIS membership for students is \$10 for the first and \$5 for each additional. Nonmembers may subscribe to the *SIS Quarterly*(s) of their choice for \$50 each per year. The opinions and positions stated by the contributors are those of the authors and not necessarily those of the editor or AOTA.

given the losses they have incurred through living. Quality of life is a personal issue that must be discussed between health care professionals and their clients so that as professionals we can ensure that our interventions are truly affecting the client's quality of life positively and from their own vantage point.

On a broader scale, quality-of-life research is important because as health care dollars stretch ever tighter, addressing quality-of-life issues becomes ever more crucial. The quantity versus quality debate is in full swing. The emphasis in the medical model has been to treat symptoms of disease at almost any cost to gain time. In contrast, the more holistic hospice model promotes comfort, pain relief, and quality rather than quantity of time. The juxtaposition of the two models must be discussed much more than it is now. Unless personal values are known and wishes are followed, a choice affecting quality of life made on behalf of another person is not likely to reveal a true reflection of that person's individual value system. Our responsibility as health care professionals is not to promote our own agendas, but to appreciate the views and protect the rights of those we serve. ■

#### References

- Atchley, R. C. (1991). The influence of aging or frailty on perceptions and expressions of the self. In J. E. Birren, J. E. Lubben, J. C. Rowe, & D. E. Deutchman (Eds.), *The concept and measurement of quality of life in the frail elderly* (pp. 207-225). San Diego, CA: Academic Press.
- Carstensen, L. L. (1991). Selectivity theory: Social activity in life span context. *Annual Review of Gerontology and Geriatrics, 11*, 195-217.
- Carstensen, L. L. (1995). Evidence for a life-span theory of socioemotional selectivity. *Current Directions in Psychological Science: A Journal of the American Psychological Society, 4*, 151-155.
- Cohn, J., & Sugar, J. A. (1991). Determinants of quality of life in institutions: Perceptions of frail older residents, staff and families. In J. E. Birren, J. E. Lubben, J. C. Rowe, & D. E. Deutchman (Eds.), *The concept and measurement of quality of life in the frail elderly* (pp. 28-49). San Diego, CA: Academic Press.
- Gentile, K. M. (1991). A review of the literature on interventions and quality of life in the frail elderly. In J. E. Birren, J. E. Lubben, J. C. Rowe, & D. E. Deutchman (Eds.), *The concept and measurement of quality of life in the frail elderly* (pp. 75-90). San Diego, CA: Academic Press.
- Larson, R. (1978). Thirty years of research on the subjective well-being of older Americans. *Journal of Gerontology, 33*(4), 109-125.
- Lawton, M. P. (1991). A multidimensional view of quality of life in frail elders. In J. E. Birren, J. E. Lubben, J. C. Rowe, & D. E. Deutchman (Eds.), *The concept and measurement of quality of life in the frail elderly* (pp. 3-27). San Diego, CA: Academic Press.
- Lawton, M. P. (1996). Quality of life and affect in later life. In C. Magai and S. H. McFadden (Eds.), *The handbook of emotion, adult development and aging* (pp. 327-348). San Diego, CA: Academic Press.
- Mroczek, D. K., & Kolarz, C. M. (1998). The effect of age on positive and negative affect: A developmental perspective on happiness. *Journal of Personality and Social Psychology, 75*, 1333-1349.
- Regi Robnett, MS, OTR/L, BCN**, is Assistant Professor, University of New England, Biddeford and Portland, Maine; [robnett@une.edu](mailto:robnett@une.edu).
- Robnett, R. (2002, March). Quality of life and aging: Exploring the "paradox of well-being." *Gerontology Special Interest Section Quarterly, 25*, 1-2, 4.

□



The American Occupational  
Therapy Association, Inc.  
PO Box 31220  
Bethesda, MD 20824-1220

**OTA**<sup>®</sup>