Rev Bras Psiquiatr 2003;25(1):31-9

Elderly people´s definition of quality of life

A definição dos idosos de qualidade de vida

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Abstract

Objectives: Senescence for some elderly people is a phase of with development and satisfaction, whereas for others is a negative stage of life. The determinants of a good quality of life in old age vary from person to person. The aims of this study were to identify: 1) the prevalence of octogenarian people who evaluate their current life as being mainly characterized by a positive quality and 2) which were the domains that they identified as being the determinants of this positive quality. A same parallel study was conducted with subjects who evaluated senescence as a preponderantly negative experience.

Methods: A random and representative sample of 35% of the octogenarian people, living residing in the community, was selected among the dwellers of the city of Veranópolis, state of Rio Grande do Sul. A semi-structured questionnaire on quality of life quality was applied as well as the scale of depressive symptoms Geriatric Depression Scale (GDS) and the index of general health Cumulative Illness Rating Scale (CIRS).

Results: Slightly more than half of the studied sample (57%) defined their current quality of life with positive evaluations, whereas 18% presented a negative evaluation of it. A group 0f 25% defined their current lives as neutral or having both values (positive and negative). Those who were dissatisfied presented more health problems according to the CIRS and more depressive symptoms when evaluated by the GDS. Satisfied subjects ones had different reasons to justify this state, however, the dissatisfied had mainly the lack of health as a reason for their suffering. The main source of reported daily well-being was the involvement with rural or domestic activities. Among the interviewed, lack of health was the main source for not presenting well-being, although there was interpersonal variability regarding what each subject considered as loss of health.

Conclusion: Possibly, for the elderly subjects a negative quality of life is equivalent to loss of health and a positive life quality is equivalent to a greater range of categories such as activity, income, social life and relationship with the family, categories which differed from subject to subject. Therefore, health seems to be a good indicator of negative quality of life, though an insufficient indicator of successful elderliness.

Keywords Quality of life. Elderly. Depression.

Resumo

Objetivos: A velhice para alguns é uma etapa de desenvolvimento e satisfação, enquanto para outros é uma fase negativa da vida. Os determinantes da boa qualidade de vida na velhice variam de sujeito para sujeito. O objetivo do presente estudo foi identificar: 1) a prevalência de octagenários que avaliavam sua vida atual na velhice como preponderantemente de uma qualidade positiva e 2) quais aspectos eles identificavam como os determinantes desta qualidade positiva. Igual estudo em paralelo foi feito com sujeitos que avaliavam a velhice como uma experiência preponderantemente negativa.

Métodos: Uma amostra randômica e representativa de 35% dos idosos com mais de 80 anos residentes na comunidade foi selecionada entre os residentes em Veranópolis, Rio Grande do Sul. Um questionário semi-estruturado de qualidade de vida foi aplicado, bem como a escala de sintomas depressivos "Geriatric Depression Scale" (GDS) e o "Índice de Saúde Geral Cumulative Illness Rating Scale" (CIRS).

Resultado: Um pouco mais da metade dos idosos estudados (57%) definia sua qualidade de vida atual com avaliações positivas, sendo que 18% tinham uma avaliação negativa da vida atual. Um grupo de 25% definia sua vida atual de forma neutra ou de dois valores (aspectos positivos e aspectos negativos). Comparados com os

Financiado pela Fundação Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES).
Received on 19/6/2001. Reviewed on 24/4 and 26/6/2002. Approved on 25/11/2002.

satisfeitos, os insatisfeitos tinham mais problemas de saúde pela CIRS e mais sintomas depressivos quando avaliados pela GDS. Os satisfeitos tinham diferentes motivos para justificar este estado, porém os insatisfeitos tinham principalmente a falta de saúde física como motivo do sofrimento. A maior fonte de bem estar no dia-a-dia citada era o envolvimento com atividades rurais ou domésticas. Entre os entrevistados, a perda da saúde física era a principal fonte de mal estar, sendo que havia variabilidade interpessoal quanto ao que cada sujeito considerava como "perda de saúde".

Conclusão: É possível que para idosos, qualidade negativa de vida seja equivalente a perda de saúde e qualidade de vida positiva seja equivalente a uma pluralidade maior de categorias como atividade, renda, vida social e relação com a família, categorias diferentes de sujeito para sujeito. O aspecto saúde parece assim um bom indicador de qualidade de vida negativa, porém um indicador insuficiente de velhice bem sucedida.

Descritores Qualidade de vida. Idosos. Depressão.

Introduction

Quality of life of elderly people

Elderliness is a qualitatively different experience for each subject. It is preponderantly good for some, 'an autumn with deep but bright tonalities' and a bad experience for others. Between these two extremes of good and bad quality, there is probably a continuum. Erikson has referred to the two extreme poles, satisfaction and dissatisfaction, as respectively the pole of 'integration' and of 'despair'. Explaining these Erikson's concepts, Kimmell et al summed up in the following way these two possibilities of emotional positioning of the elder facing the old age: 'if the elderly subject manages to build a secure sense of the ego and a perception of his/her legacy, be it through the children or the work, he/she maintain an ego integrity, whereas the incapability to provide for a solution for this conflict results simultaneously in disappointment with his/her own self (with the subject proper) and, therefore, despair'.

In fact, it seems empirically probable that the experience of being aged be emotionally variable between different subjects, being agreeable for some of them and bad for others. Whether elderliness will be an enjoyable stage of the vital cycle will depend on objective factors of this subject's life and on the subjective interpretation of this reality by the elderly person. It will depend partially on the subjective interpretation of the elderly and in part on the objective contingencies of their histories. Therefore, the positive quality of life – as well as the negative – of elderly people depends on the subject's internal variables (his/her emotional attitude facing the facts of life) and on external variables (contingencies, environmental resources).

The quality of life depends on the emotional interpretation the subject gives to the facts and events. The quality of life is increasingly acknowledged as an assessment strongly dependent on the person's subjectivity. In the specific field of physical health, for example, there is a great variability between people regarding their capacity of facing up to physical limitations and diseases and their expectations concerning their health. The individual concepts can have a determinant influence in the perception and valuation people have about their health condition. Thus, two persons with the same functional state or the same 'objective' health condition (for example, degree of rheumatic arthritis), can have very different qualities of life due to these subjective aspects.

The same contingency or loss – such as blindness, for example – will not be the same for two different subjects, as a lost function could have different emotional importance for each of them. As reminded by Sadavoy, the magnitude of the reaction of the elderly person to the loss depends at a certain degree on the amount of pride and emotional investment that this person had in the lost function.

Several internal emotional/psychical characteristics influence the possibility of having a pleasant elderliness. Characteristics such as the interpretation of losses, the previous personality and even the beliefs and positions facing aspects like death and separation can help keeping, developing or losing the well-being in elderliness. An internal characteristic highlighted by Rowe & Kahn as the most important one is the 'resilience', the emotional capability of recovering from stressing factors. According to Sadavoy,[4] the greatest developmental task of elderliness is to find 'restitution' for the inevitable biopsychosocial losses associated to this stage of the life cycle. In Goethe's[6] words, 'there is no art in getting old, but it is an art to endure elderliness'. For many elderly people, the task of recovering from stressing factors is hampered due to the cumulative effect of losses close in time, when a new loss occurs before enough time had already passed in order to allow the resolution of grief.

Besides these internal aspects, the external contingencies vary enormously from person to person. The loss of independence does not happen to everybody and when it occurs follows different paces. The loss of financial resources is common, although its degree be variable. Many elderly people –in our society frequently more females than males – will have to face up to widowhood. Different 'organic scenarios' are possible: the number, quality and the intensity of their health limits vary for each elderly person, from subjects whose health is kept in the standards of young adults (well-succeeded elderliness) up to those without any social life. Even the age is variable among elderly people, sometimes ranging more than 30 years.

After the occurrence of a negative life event, the presence of

certain factors – such as a solid family network – could smooth the impact of the event on the subject's well-being. Reynolds III et al.[7] compare these protecting factors to 'buffers' or variables which – if present – could minimize the effect of a negative event on the well-being. For this author, the negative events are *challenges* to the well-being in elderliness, and the 'buffer' variables such as economic resources or family support – would act to keep the well-being after the occurrence of a 'challenging' event. The very existence or not and the quantity of these 'buffers' also vary among elderly people. In a developed society an incapacitating disease could have a lower impact over the quality of life than that of the same disease in a society without resources such as a day-hospital or home oxygenotherapy. Widowhood in an environment of migrating elderly people, in which they lost their friendships of the youth when they moved from their city, is certainly worse than widowhood in a community without the mobility of migration.

Therefore, elderliness having a preponderantly *positive* quality for elderly people depends on the internal emotional coordinates and on the external coordinates or on the contingencies. Whether elderliness will be an enjoyable stage in the elderly's life depends on the subject's emotional resources as well as on the intensity of stressing factors and resources offered by the environment to the subject (buffers). As these internal and external coordinates may range from very favorable to intensely unfavorable we can understand how the intersecting or resulting point of these two axis vary from subject to subject. This intersecting point between the external reality and the opinion and feeling about this reality can be called the subject's 'quality of life'.

Measuring quality of life

As suggested by Farquhar,[8] there are two ways to measure the quality of life: through structured and non-structured interviews. When using structured instruments such as scales, the concept of quality of life actually used is the researcher's, whereas the methodology used in non-structured interviews allows subjects to identify the factors which contribute for their positive or negative attribution to the quality of life.

There is a great number of structured scales and tests developed to measure the quality of life. They vary widely in their conception, construct and content demonstrating that there is no agreement about what is a measure of the quality of life. The validity of the measurements of quality of life is difficult to be established as there are no ways to determine to which gold-standard the scales should be compared. Besides, up to now most scales have been developed by professionals, based on their standards and definitions about what determines the quality of life. However, feelings about life are subjective and what is valued as an important factor for the well-being of one subject may be not significant for another one. It may happen that for an elderly person the cultivation of spirituality and not the existence of a network of friends be one of the most decisive factors for the subject's good quality of life. In this case, a study about quality of life using a structured scale, which measures the domains of 'social life', 'physical health' and 'psychological health', will not measure what in fact makes positive this specific subject's quality of life (in this example, spirituality).

Due to the inherent problems of using structured measuring instruments, non-structured interview techniques have an important role to provide a better understanding about the quality of life. In this sense, Slevin et al,[9] seeking the correlation between scores obtained by professionals and by patients themselves, have concluded that whether a reliable and consistent method to measure the quality of life for cancer patients is needed, this instrument should come from patients and not from physicians and nurses. Similarly, Calman[10] suggests that the quality of life can only be individually described and measured: according to the author, 'as the components of the quality of life are personal, the most adequate procedure to measure it seems to be the use of the individual definitions of each interviewed.'

The aim of this study was to identify 1) the prevalence of octogenarian people who assessed their current life as having a preponderantly positive quality and 2) which domains they identified as determinant for this positive quality.

The same study was performed in parallel with subjects who assessed their elderliness as a preponderantly negative experience.

Methods

Population

Veranópolis is a semi-rural, Italian-settled town, in Southern Brazil, with 18,000 inhabitants, most of them rural workers. For more than ten years, the Institute of Geriatrics and Gerontology of the PUCRS has been studying this community, aiming at identifying health patterns of octogenarian people living in the community. Veranópolis' city hall in the year of the current study had the records of all 219 subjects aged above 80 in the town.

Sample

Out of a population of 219 subjects living in the community aged above 80, a random representative sample of 77 subjects (77/219 or 35%) was designed. The calculation of the sample's size was performed with the EPI-INFO package version 6.02. A simple random sampling method was used to choose the subjects to be included in the sample, out of the allotment of 77 names from a list with all the 219 names of the town's octogenarian population. In this 77-subject sample, 4 refused to participate in the study. Other 4 subjects (5% or 4/73) met DSM-IV criteria for dementia and 2 showed DSM-IV criteria for delirium. Therefore, the final studied group had 67 subjects.

Data collection

Data were collected by one geriatric physician and one psychiatrist. Each researcher applied part of the instruments being the global geriatric exam applied by the geriatric physician and the semi-structured clinical interview for quality of life, by the psychiatrist. All subjects who participated in this study gave

their informed consent. This study was approved by the Ethics Committee of the Federal University of the State of São Paulo (UNIFESP), Paulista Medical School.

Scales and procedures

a) Quality of life. A brief questionnaire with 5 non-inductive questions and open answers was proposed to the subjects. Answers were written down and later categorized. Subjects were asked: 1) How would you describe the life you are currently living? 1b) Why would you say that? 2) What in your current life is well? 3) What in your current life is not well? 4) What could happen to make your life better than now? and 5) What could happen in your life to make it worse than now.

In a first pilot study the term 'quality of life' was present in the place of 'life' in the questions above, but the population of this community found it more difficult to understand it. The replacement of the term 'quality of life' was a methodological option in order to maintain the construct's intelligibility without losing its validity regarding the way in which analogous questions were first proposed by an English study.[8] Apart from this adaptation, questions were the same of that previous study, differing from the current one for not having any quantitative measure for depression or physical health.

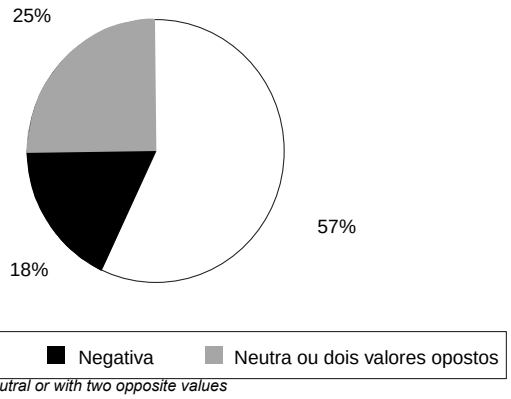
b) General health/depressive symptoms. All subjects underwent a global geriatric evaluation which included a clinical interview and physical and neurological exams, as well as a structured interview with specific questions about the presence, duration, main symptoms and treatment complications of pulmonary chronic disease, cardiac disease, aterosclerotic disease, diabetes mellitus, malignant neoplasia, osteo-articular disease and illnesses on the sensorial organs. The Cumulative Illness Rating Scale (CIRS)[11] index was used to quantify the general medical comorbidity. The CIRS is a validated instrument that quantifies the dysfunctions in six organic systems (cardiorespiratory, gastrointestinal, genitourinary, muscle-skeleton, psychoneurological and endocrine-general system) in a severity scale from 0 to 4 points. Other assessed aspect was the capability of developing six daily activities (DAs) listed by Katz et al,[12] as well as the ability of performing without difficulties other eight daily physical activities, common in this community. The geriatric depressive scale (GDS)[13] was used to measure depressive symptoms.

c) Religiosity index. The participation in religious activities was measured with the religiosity index adapted from Ljungquist and Sundström.[14] The index was the total sum of the following components: a) for the question 'are you a subject...' the answer 'intensely religious' received 50 points, the answer 'religious' received 25 points, 'hardly religious' received 5 points and the answer 'not religious' received 0 points. b) If the person performed novenas or had gone to the community spiritual patroness' (Our Lady of Lourdes) party in the last year, he/she received 10 points. c) If the person watched religious broadcasts on the radio or TV or followed daily the chaplet pray of the seminarists on the radio he/she received 10 points. d) In case the person used to pray daily he/she received 10 points. e) if the person attended daily the religious celebration (or accompanied it by the radio or TV), he/she received 10 points, weekly 5 points, monthly, 2 points and occasionally, 1 point. The religiosity index was created adding the item 'a' to the mean of aspects 'b'+'c'+'d'+'e', dividing the result by two.

d) financial satisfaction and objective socioeconomic situation. The questionnaire proposed by Gray et al[15] was applied to the subjects' perception about the adequacy of their earnings in four areas of needs: 'daily needs, 'expenses with physicians and medications', 'non-expected expenses' and 'leisure activities'. Subjects were asked how their earnings sufficed for each activity above and received 1 point for the category 'does not fit', 2 points for the category 'nearly suffices', 3 points for the category 'it is sufficient' and 4 points for the category 'easily'. The total sum of this punctuation was the index of financial satisfaction. The objective socioeconomic situation was assessed with a two-component index: a) income: the income of each subject of the family was calculated based on the total income of the family's subjects and on the number of the subjects who lived at home. The result was the individual income of each family member. The income of all participants was listed and values up to the first quartile received 2.5 points, up to second quartile meant 5 points, up to the third quartile, 7.5 points and above the third quartile had a punctuation of 10 points; b) social localization of the home: visiting the domiciles, they were categorized by the same evaluator according to poverty conditions (2.5 points), lower middle situation (5 points), higher middle (7.5 points) or higher (10 points) situation. The criterion of domicile received weight 2 in the index of socioeconomic level and income received weight 1.

Statistics

The t test was used to compare the mean punctuation in the general health index, in the scale of depressive symptoms, in the index of financial satisfaction, in the socioeconomic level, in the religiosity index and in the scales of functionality for daily activities of both subjects with positive and negative quality of life. Presence of significant differences in the gender distribution between both groups was sought with the chi-square test. The significance level was $p \leq 0,05$.



Positive Negative Neutral or with two opposite values
Obs: 67 subjects

Figure 1 - How would you describe the life you are living?

Results

How would you describe your current life?

Slightly more than half of the studied subjects (57% or 38 out of 67) defined their current quality of life with positive assessments, while 18% (12/67) had a negative assessment of their current quality of life. A percentage of 25% (17/67) of them had a neutral assessment or two opposed values (Figure 1).

When comparing satisfied and dissatisfied subjects, the latter had more health problems according to the CIRS, more depressive symptoms according to the GDS and a worse punctuation in the scale of economic satisfaction (Table 1). On the other hand, the functionality to perform daily activities, the religiosity and the objective socioeconomic level of dissatisfied subjects were not different from satisfied ones. Excluding 17 subjects with neutral assessments or with two opposed values, we noticed that the presence or absence of satisfaction among the remaining 50 subjects was not associated to the gender (chi-square; p=0.37): a percentage of 85% of men (17/20) and 70% of women (21/30) assessed positively their quality of life.

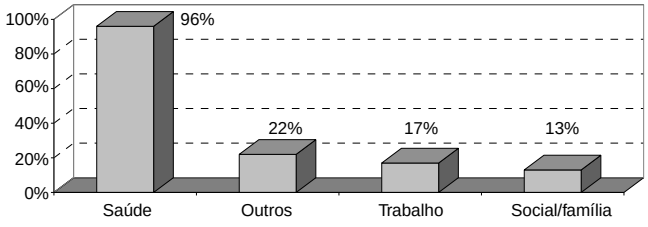
Why would you say that? (determinants of a good quality of life)

Among 38 subjects with positive assessment of their current life and 17 subjects with assessments with opposite values, 53 subjects mentioned at least one reason for assessing positively their current life. In Table 2 we present the determinants of a good quality of life. Good health (for 43% of the subjects or 23/53), good relationship with the family (32%, 17/53) and financial security (28%, 15/53) were the most reported domains. Figure 2 represents the percentage of the 53 subjects who mentioned each of the different domains or determinants.

Why would you say that? (determinants of a bad quality of life) A total of 23 subjects (among those who assessed their current life either negatively or with two opposed values) mentioned at least one negative determinant for their quality of life. According to the interviewed, the determinants of a bad quality of life were those presented in Table 3 and Figure 3. Bad health was the determinant for a bad quality of life mentioned by 96% (22/23) of the subjects who cited negative determinants.

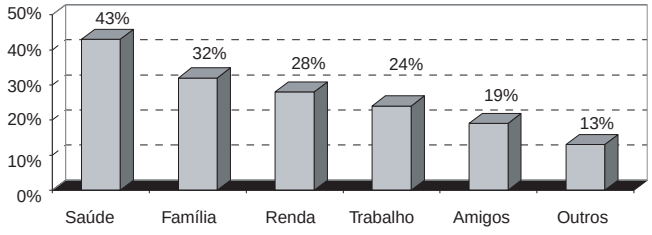
What is well in your current life?

For 66 subjects (either situated in the group of satisfied, dissatisfied, or neutral subjects) who mentioned aspects of their current lives that were well, the most remembered category as a source of satisfaction was the 'activity' (or work). Among 66 subjects who mentioned at least one aspect which was well, the 'activity/job' was mentioned by 40 (61%) subjects. Most people who mentioned job as an aspect that was well, referred to the pleasure/possibility of performing any job (work) (37/40), but a smaller part (3/40) referred to retirement or to the fact they did not need to work any more.



Health Others Work Social Family
Note 1: There were 23 subjects who mentioned at least one determinant of a bad quality of life.
Note 2: The percentage represented the rate of the 23 subjects who mentioned that domain.

Figure 3 - Why would you say that? Determinants of a negative quality of life.



Health Family Income Work Friends Others
Note 1: There were 53 subjects who mentioned at least one determinant of a good quality of life.
Note 2: The percentage represented the rate of the 53 subjects who mentioned that domain.

Figure 2 - Why would you say that? (Determinants of a Positive quality of life)

Table 1 - Comparison between subjects with positive and negative quality of life regarding different variables.

	Elderly people with Positive Quality of life (n=38) mean (standard deviation) variability	Elderly people with Negative Quality of life (n=12) mean (standard deviation) variability	t test p value
Mean age	84.8 (±3.8) 80-95	82.5 (±2.9) 80-89	.066 ns
Functionality (Number of the 14 easily performed DA)	12.8 (±2.1) 2-14	10.2 (±4.9) 2-14	.099 ns
Religiosity index (higher values signify MORE religious activities)	33.0 (±9.8) 8-48	37.4 (±7.3) 25-48	.163 ns
Socioeconomic situation (index of family's socioeconomic situation, higher values mean a BETTER situation)	15.4 (±3.2) 3.5-21.7	14.6 (±1.8) 12.5-18.0	.408 ns
Index of financial satisfaction (higher values mean MORE satisfaction)	6.8 (±2.0) 3-10	5.2 (±1.2) 3-8	.003 s
Index of general health - CIRS (higher values mean LESS health)	5.7 (±2.7) 1-11	7.7 (±2.8) 3-12	.034 s
Depressive scale GDS (number of depressive symptoms in a list of 15 symptoms)	3.2 (±2,2) 0-9	5.3 (±2.9) 0-9	.014 s

S = significant; NS = non significant.
DA = daily activities/ CIRS = Cumulative Illness Rating Scale / GDS = geriatric depression scale.

In decreasing order, the other factors that were well in their current life were: family/social (for 24/66 or 36%), health (for16/66 or 24%), hobby/leisure (for 14/66 or 21%), pleasant activities (such as eating, maté tea for 8/66 or 12%) and emotional/religious aspects (for 6/66 or 9%).

What in your current life is not well?

A total of 64 subjects had an answer to this question, although 16/64 (25%) answered that there was nothing bad in their current life. The most recalled domain by the 64 subjects who answered to this question was 'bad health', a source of distress mentioned by 39% of them (25/64). Other causes of loss in the quality of life were mentioned nearly in the same frequency: not being able to perform the job (26%) and difficulties in the family (22%). Problems with the income were mentioned by 6 subjects (6/64 or 9%).

What could happen to make your life better than now?

A total of 63 subjects mentioned at least one aspect that could improve their quality of life. Given the prevalence of cognitive difficulties among the octogenarian, questions such as this may demand a too high level of abstraction for several subjects, as was observed. Contrary to the previous questions, many elderly people had difficulties to answer this question.

For this question, 52 subjects gave at least one example of something that could improve their life, and 11 subjects stated that their life was already well and nothing lacked (total of subjects with any answer =63). The most recalled domains were in decreasing order: health (33/63 or 52%), income (11/63 or 17%), 'I do not need anything more' (11/63 or 17%), aspects about death (such as dying surrounded by relatives or having people back for 8/63 or 13%)

What could happen to your life to make it worse than now?

A total of 61 subjects had an example of something that could decrease their quality of life. Again health – both their own and their family members' – was the most mentioned factor for a possible negative impact in their quality of life. A percentage of 59% (36/61) mentioned health. The other factor that could decrease their quality of life were: family problems (25/61 or 41%), money problems (5/61 or 8%) and death (3/61 or 5%).

Discussion

A little more than half (57%) of the studied elder defined their current quality of life with positive assessments, and 18% had a negative assessment of their current quality of life.

Table 2 - Why would you say that? Determinants of a POSITIVE quality of life.

1	**Domain: health/capabilities**	23/53 (43%)
1a	Happiness because life 'me piazzi', because a hit hurts and another one does not, life is good.	5 subjects
1b	Health, I am still well, I'm even healthy, I'm healthy, I have little diseases.	17 subjects
1c	To walk.	3 subjects
1d	I don't have any pain.	1 subject
1e	I don't need help.	1 subject
1f	I have appetite.	1 subjects
2	**Family**	17/53 (32%)
2a	The family members are well	1 subject
2b	My family members love me, I get along with my relatives, I get along at home, my children love me, my relatives love me, I feel well with my children.	6 subjects
2c	There are no quarrels between my family members.	1 subject
2d	My children make me safe.	2 subjects
2e	I live for my children I can help my children.	3 subjects
2f	I have a husband, I didn't lose my children.	1 subject
2g	My children are good.	1 subject
2h	My children use to visit me, my grand-sons came every afternoon.	2 subjects
2i	My grand-sons live near me, I live near my children.	2 subjects
2j	I'm the boss around here, I'm free as nobody stops me, I'm free to come back from a party when I want, I do what I want.	5 subjects
3	**Income/ assets/ safeness**	15/53 (28%)
3a	Now I can manage, I have some spare money, I don't worry about money.	3 subjects
3b	I have everything, one can drink and eat, I live well, I don't have any difficulty.	10 subjects
3c	I have my own money, I bye what I want.	1 subject
3d	I'm independent, I can manage.	1 subject
3e	I abandoned this issue.	1 subject
4	**Work**	13/53 (24%)
4a	I don't have to work so much, The work is light and I'm rested, If I want to work I do.	5 subjects
4b	I'm a friend of working, I can do the job, life is beautiful as one has what to do and not gets lost nearby, I have disposition to work.	8 subjects
5	**Friends and carers**	10/53 (19%)
5 a	The caress is well, everybody loves me.	2 subjects
5b	To see friends, to go out with friends.	3 subjects
5c	I have company.	1 subject
5d	I get along with the neighbors.	1 subject
5e	People come to visit me.	2 subjects
5f	Parties.	2 subjects
6	**Others**	7/53 (13%)
6 a	I'm old, I've lived very much, with all I have gone through I'm more than well, It doesn't seem true to me that I'm so old.	4 subjects
6b	I give the example.	1 subject
6c	I accept that I'm getting old, nobody makes me forget that I'm old.	2 subjects
7	**leisure / praying**	4/53 (7,5%)

Note 1: There were 53 subjects who mentioned at least one reason to assess positively their current quality of life.
Note 2: The sum of percentages of all categories does not reach 100% as each subject may mention more than one category.
Note 3: The sum of subjects grouped in each domain does not agree necessarily with the sum of subjects in each of the sub-items of this domain, as each subject can mention more than one answer from each domain. Subjects with more than one answer in the same domain only were counted once in the sum of subjects with at least one answer of that domain.

Dissatisfied subjects had more health problems and more depressive symptoms, being less satisfied with their economic situation when compared to those who were satisfied. Both groups neither had different objective economic situations, nor differed in terms of religious practices. These data agreed with those of Courtenay et al[16] who showed that religiosity was not linked to the satisfaction with life among elderly people and were opposed to the results of Edwards et al[17] who evidenced that the socioeconomic level was an important factor for satisfaction.

It is more likely that the general health and depression be more strongly related, even in a casual way, to the satisfaction with life and that financial dissatisfaction be a non-related but simultaneous occurrence of dissatisfaction with life, derived from the same determinants. The fact that there was no difference between the groups of satisfied and dissatisfied elderly people regarding their socioeconomic level supported this impression.

The reasons mentioned as determinants of these positive and negative conditions for subjects with good quality of life and subjects with bad quality of life are shown in tables 2 and 3. While the determinants of a *negative* quality of life were limited to only one reason – in this case health – the determinants of a *positive* quality of life were at least 3 or 4, among them health. We may conclude from this difference that, while elderliness with satisfaction is a state which varies from subject to subject, elderliness with suffering is a state with only one determinant, that is, health. There could be several types of elderlinesses with satisfaction but a bad elderliness would be almost a synonymous of illness. What a 'well-succeeded elderliness' be obeys to different criteria of success from subject to subject, being success for some people the presence of a good family relationship and for others the presence of good assets and for others the presence of a good health condition. Regarding subjects with a bad quality of life, the determinant is almost exclusively a bad health condition.

A consequence of this finding for the research about the concept of quality of life is the possibility that positive and negative quality of life could be *different* categories. At least in this group of elderly people, it seems inadequate to define the positive as the inverse of negative, in case the categories of the interviewed themselves were used. It is possible that, for the elders, a negative quality of life would be equivalent to a loss of health and the positive quality of life would be equivalent to a greater range of categories, different from subject to subject. Therefore, in case the study's objective be the identification of negative indicators of the quality of life, health seems to be one of the most important concepts. However, if the study's objective is to include also positive indicators, indicators of well-being and good quality of life, thus, aspects such as activity, income, social life and relationship with the family should be included. Health seems to be a good indicator of negative quality of life although an insufficient indicator of a well-succeeded elderliness.

A bias that might have occasionally interfered in the outstanding place given to health in the answer to some of the questions is the fact that the interviewed identified the interview's staff with the medical milieu. This aspect could have influenced to overvalue health as a cause of losing quality of life. The fact that elderly people did not mention the financial dissatisfaction as the main factor of a negative quality of life lead us to think also about the hypothesis that the values of elderly people be different. Have elderly people a more 'depurated' concept about life by not valuing the financial dissatisfaction as the determinant of a negative quality of life?

Concerning to 'what is well in your current life', of note that health does not stands out. What gave more pleasure (good quality of life) to the interviewed was the work, what may be surprising in a population of retired subjects and those in late elderliness. Most subjects who mentioned the work (37 subjects) were satisfied with the accomplishment of activities, while only 3 subjects were satisfied for not having to work.

The importance that domestic and/or rural activities have for these elderly people agrees with the theory of the 60's that situates the 'activity' as a determinant of well-aging, developed by a group of researchers of Chicago. According to a review by Neri,[18] the basic notion of this theory of activity is that the more active are the elderly people the greater their satisfaction with life. According to a research about satisfaction with life among elderly people, the effects of activity on the satisfaction

Table 3 - Why would you say that? Determinants of a NEGATIVE quality of life.

1	**Domain: health**	22/23 (96%)
1a	I feel weaker, I've been tired for several days, I can't make any effort.	5 subjects
1b	I can't go where I want to, It's difficult to walk, I have to stay at home.	5 subjects
1c	I lose my temper, I don't have any joy and I'm not willing to go out, I don't have pleasure doing anything.	3 subjects
1d	I'm ugly.	1 subject
1e	Disease. Health. The leg doesn't help me, I feel pain, I'm sick.	11 subjects
2	**others:** I'm too old, I see myself as old, the years have passed by, I'm afraid of the future, I'd like to have my children young again.	5/23 (22%)
3	**Job**	4/23 (17%)
3a	I have less interest in working.	1 subjects
3b	I can't do the job, I can't catch up with the job.	3 subjects
4	**social/family**	3/23 (13%)
4a	No one comes to visit me.	1 subjects
4b	Grief.	2 subjects

Note 1: There were 23 subjects who mentioned at least one reason for negatively assessing their current quality of life.
Note 2: The sum of percentages of all categories does not reach 100% as each subject can mention more than one category.
Note 3: The sum of subjects grouped in each domain does not agree necessarily with the sum of subjects in each of the sub-items of this domain, as each subject can mention more than one answer from each domain. Subjects with more than one answer in the same domain only were counted once in the sum of subjects with at least one answer of that domain.
Note 4: colloquial expressions, in Italian or with grammar errors were not modified in this and in the following tables. (N.T – in Portuguese/ in English the translator did not maintain the grammar errors)

would be mediated by other internal variable, more studied in the 70's, the so-called 'sense of personal control'.[20] According to the point of view developed from then onwards, activity could be a determinant for the satisfaction, due to the fact that it enables people to experience a feeling of control over the environment and the events of their life. Acting in the opposite sense, the probable losses of elderliness would represent an increasing risk for the experiencing of personal control.

Neri[18] discusses in different ways this causal relationship between activity and satisfaction, thinking that this relationship might be 'inverse', that is, more satisfied subjects would be more active. Other aspects interrelated with the activity is the 'involvement', as activities such as dealing with the vineyard, tying a tomato plant, sewing, collecting firewood are contributions for the family, being the traditional nuclear family a concept which is also valued in this community.

Recurrently, the activities mentioned as a source of pleasure in the studied sample had a significance of usefulness or an 'idea of productivity'; they were activities which had a finality in daily life. Called by some interviewed as 'lending a hand', these daily life activities characteristically were concrete and effective contributions for themselves or for the group and were not activities for leisure or physical exercise. There was also a significance of a shared interpersonal involvement, such as baking a cake or gardening. Coke[19] investigated the notion that elderly person's satisfaction originates from developing significant roles and Rosow[20] explored the idea of satisfaction as derived from serving other people. Reviewing the literature about satisfaction with life, we found few studies which developed the notion of satisfaction as derived from 'doing with' 'jointly with' the new generations.

Other characteristic of the mentioned activities is that they did not differ from those with which subjects were involved during their lives and they were not new routines, started after retirement. In a community in which the domestic and rural activities were performed along all their lives, in elderliness there is the opportunity of continuity of roles, and possibly this continuity be the source of pleasure found by the interviewed in work. For elderly people from industrial communities, who in the past performed job routines that could not be maintained after 80 years old, it is likely that the impossibility of continuity be an additional factor for grief and dissatisfaction. Further study is needed to verify if for the latter the recommendation of 'activity' aiming at reaching satisfaction, a new activity regarding their routines as young adults, will have this supposed result in terms of well-being.

For the question 'what in your current life is not well', 25 subjects mentioned loss of health as the cause of a bad quality of life. Among them, nearly half did not give more details about what was called 'health' while the other half did. Therefore, the concept of loss of health for some subjects is the presence of pain, for others is to depend on others, and still for others is not being able to walk. Therefore, we may conclude that health – or the loss of it – is not the same thing for each subject, meaning for some of them the loss of encouragement (6 subjects), and for others the presence of pain (7subjects), for others a decrease in the functionality and autonomy (5 subjects).

Therefore, the current study has identified a community with a predominance of elderly people who were happy with their current lives. Satisfied subjects had different reason to justify this condition, however dissatisfied subjects cited lacking of good health as the main reason for suffering. The greatest mentioned source of pleasure in the daily life was the involvement with rural and domestic activities. In this community, these activities have an utilitarian nature and are activities which these subjects had performed along all their lives. Conceptually, the 'activity' could be associated to 'satisfaction', be it to reinforce a sense of personal control, by signifying prestige in a rural community which values the entrepreneur or for signifying involvement with the family. Alternatively, activity can be associated with satisfaction as it signifies the maintenance of one's identity in face of his/her group. Thus, satisfaction with the engagement in domestic and/or rural activities would come from the signification that this job could have as a manifestation of maintenance of the identity of the subject in the group. Among the interviewed, the loss of health was the main source of distress, and there was interpersonal variability regarding what each subject considered as 'loss of health'.

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