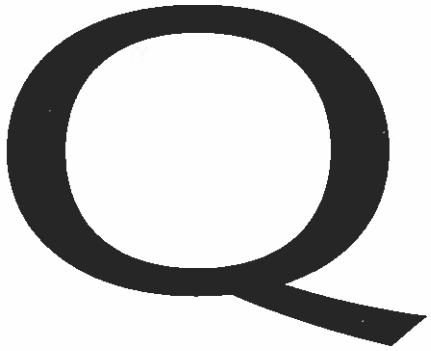

Qualitative Research on Aging

The complexity and wealth of lived experiences that exemplify the health and lives of older adults call for research approaches that fully capture their richness and breadth. Qualitative researchers believe that the intricacies of the human experience cannot be understood adequately by depending only on the "objective" measurements of positivist researchers, nor do they believe that objective reality can be known even if it exists. Rather, they believe that there are multiple realities that are equally viable, realities that can be uncovered by asking participants how they interpret and construct their social worlds. In place of statistics, the words, meanings, contexts, and conceptualizations of persons form the fundamentals of this approach.

Qualitative Research as a Method

Qualitative research is an umbrella term often used interchangeably with *interpretive/constructivist research* or *naturalistic inquiry* and is used in at least two ways. Sometimes, the term refers to a diverse set of methods or procedures for conducting research, and numerous discipline-specific qualitative research traditions have developed. For example, sociology lays claim to symbolic interactionism, grounded theory, and ethnomethodology; psychology to hermeneutics and ecological psychology; anthropology to ethnography; philosophy to phenomenology; and sociolinguistics to discourse analysis. Other disciplines, such as health services research, nursing, education, and marketing, have developed their own styles by borrowing liberally from other traditions. The quest for an organizational map of qualitative methods has been likened to the search for the Holy Grail as the methods derive from 30 or more traditions and multiple disciplines characterized by a proliferation of conceptual jargon.

Most of the research on health-related issues of older adults appears to draw on four preferred methods. The first is *grounded theory,* the intent of which is to generate new theory or to add to, or revise, existing theory. The second, *ethnography,* describes and interprets the meaning of behavior in a cultural context and is both a process and an outcome. The third is *phenomenology,* which seeks to capture the lived experience of a person as it relates to a specific concept or phenomenon. The last preferred method is *discourse analysis,* in which the participant's words are analyzed for verbal interaction and dialogue.

Qualitative Research as a Philosophy

In contrast to the understanding of qualitative research as method, the term also denotes a philosophy or worldview in competition with quantitative research and based in positivism. Beginning in the late 1970s, adherents to the philosophical position of postpositivism challenged the tenets of positivist inquiry, arguing that there could be multiple interpretations of

reality and that researchers' own feelings and values influence the research process and findings. Thus, although qualitative inquiry breaks down the complexity of the real world, at the same time it is deeply embedded in the socialization of its adherents and practitioners. It is not unusual, however, for authors to vacillate between these methodological and philosophical traditions without stating clearly which of the two forms the basis for their approach.

Qualitative Research in Health and Aging

Whether as a method or a philosophy, qualitative research has greatly enriched the study of health and aging. Observational fieldwork, in-depth interviews, and analyses of text—separately or in combination—interpret the meanings of what people say, do, and think in topics encompassing both structure and process. For example, health researchers have explored social isolation in nursing home residents, the organization of work in health care settings, the experience of stroke recovery, and resilience in the face of chronic illness.

A common thread among all of these studies is that researchers place themselves in direct contact with, or in the immediate proximity of, those being studied. This enables them to appreciate the processes of the social world and to incorporate the realm of subjective experience (including their own) in the production of data. Researchers and participants become mutually interactive and influence each other simultaneously.

Evaluation of Qualitative Health Research

Qualitative researchers resist the view that their investigations of the subjective aspect of experience lack scientific rigor, spawning a growing body of literature for evaluating qualitative studies. A broad evaluation can be made by asking two questions. First, was the method of data collection comprehensive enough to support robust and rich descriptions of the event under study? Second, were the analyses appropriate and the findings corroborated? Alternatively, one may use four criteria—credibility, transferability, dependability, and confirmability—that mirror the positivist paradigm: internal validity, external validity, reliability, and objectivity. At the policy level, the U.K. government has devised a list of 18 appraisal questions to evaluate qualitative evidence.

The criteria used to evaluate grant applications and manuscripts in health research have been based traditionally on quantitative principles. However, the increasing ability to guide the evaluation of qualitative studies bodes well for the success of qualitative research applications. The growing maturity and acceptance of qualitative inquiries guarantee that the intricacies of human experience will be recognized as a stand-alone valued avenue of health and aging research and not only as an "add-on" to quantitative investigations.

—Barbara J. Payne

See also Demography of Aging; Epidemiology of Aging; Longitudinal Research; Social Networks and Social Support

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Quality of Life

Medical advances during the past century have dramatically increased average life span and changed the

course of illness during older age. Many illnesses previously considered to be terminal are now treated as chronic conditions. As people live longer with chronic illnesses, quality of life has become an increasingly important issue to older adults and researchers alike. The current emphasis on quality of life during later life has shifted the focus of geriatric health care from increasing the quantity of years to increasing the quality of years. Despite increased knowledge of disease causes, healthy lifestyle changes, and successful treatment options, there is scant evidence that rapid advances in science and medicine have resulted in improved quality of life for elder adults. This entry reviews the emergence of quality of life as a concept and major goal of health and social policy, explores its meaning and measurement, details a new approach to assessment, and suggests possible directions for future research.

Historically, quality of life has been a concern of the humanities, religion, philosophy, sociology, medical science, and social gerontology. Although the concept existed earlier, quality of life did not receive significant attention until after World War II. In 1948, the World Health Organization (WHO) expanded its definition of health to include "health as a state of complete physical, mental, and social well-being." Simultaneously, dramatic social inequities and health disparities across Western societies captured the attention of researchers. Concerns about quality of life and poverty during older age gave rise to reform movements, Social Security, and the policy initiatives of the 1960s' "War on Poverty" in the United States.

Although not defined, quality of life was identified as a goal during the mid-1960s in the *Report of the President's Commission on National Goals in the United States.* The term was used primarily in reference to objective social indicators such as number of households with telephones, material wealth, divorce rates, and crime statistics. Following the political and social upheavals of the 1960s, emphasis shifted from objective indicators to subjective dimensions of quality of life such as personal freedom, enjoyment, and caring. It was argued that quality of life is a state of mind rather than a state of health or wealth. Because people respond to subjective impressions, their feelings and perceptions need to be considered when assessing quality of life.

The increasing use of the term *quality of life* in the popular press of the 1960s was followed by its use in medical research. The term first appeared in academic literature in the *International Encyclopedia of Social Sciences* in 1968 and in *Index Medicus* during the mid-1970s. As interest in this topic grew over the subsequent 30 years, numerous health-related instruments were developed as medical research shifted its focus from mortality and morbidity to the broader impact of chronic disease on quality of life.

Although there is a burgeoning research literature devoted to the measurement of quality of life, a precise definition remains elusive. Despite this limitation, a consensus has emerged that quality of life is multidimensional in nature and must include both objective and subjective dimensions. Current researchers often cite the WHO's definition of quality of life as an individual's self-perception of his or her position in life in the context of that individual's own culture and value systems. Quality of life measures are increasingly used to evaluate the value of medical and social services, assess life course changes, and distinguish disadvantaged population groups. Consequently, our understanding of the relationship between specific therapeutic interventions and quality of life across the life span has increased.

Research suggests that what constitutes quality of life changes with age. When older adults are asked about their primary values and concerns, their own health and the health of significant others are cited most often as vital to a good quality of life. However, a host of other issues—physical, social, and psychological—are also regarded as important. As a result of the expanding definitions of quality of life in today's geriatric population, medical professionals are beginning to focus on treating the whole person while also appreciating that for some patients a long life is not necessarily a good life.

Not surprisingly, the process of defining quality of life across different cultures, geographic areas, age groups, and socioeconomic conditions is a complex task. In reviewing the global research literature, one finds that the definitions used are as numerous

and diverse as the methods of assessment. Despite increased research and public policy attention, few instruments exist specifically to measure quality of life in older adults. Definitions for quality of life among this group range from broad socioeconomic measures to narrow health-related measures.

As indicated previously, health alone does not determine most older people's perception of their quality of life. Someone in good health can claim a poor quality of life, whereas someone in poor health can claim a good quality of life. Some critics argue that if quality of life is defined primarily, or even partly, as a state of mind, it becomes impossible to develop an objective measure for quality of life. Be that as it may, most researchers embrace a broad approach to this important topic.

When measuring quality of life in older adults, a valid multidimensional approach—one allowing for individual values and both objective assessments and subjective perceptions—is most useful. A comprehensive measure should evaluate a variety of dimensions deemed to be important by older adults. In particular, because chronic illness can exert a wide range of effects, quality of life measures must encompass at least three overarching dimensions. Building on prior research, the Wisconsin Quality of Life Index (WQLI) was developed as a multidimensional instrument for older adults encompassing both objective and subjective criteria and spanning multiple dimensions of individuals' lives (Figure 1).

The WQLI allows information to be collected from multiple points of view and over extended periods of time. It is organized to evaluate the following dimensions: (a) objective quality of life indicators such as housing and environment, (b) meaningful activities, (c) psychological well-being, (d) physical health, (e) social relations, (f) economics, (g) activities of daily living (ADLs), (h) physical symptoms, and (i) achievement of personal goals. The WQLI is designed to be self-administered, easy to use, and appropriate for a variety of research and clinical settings. If an older adult is unable to read or write, someone can

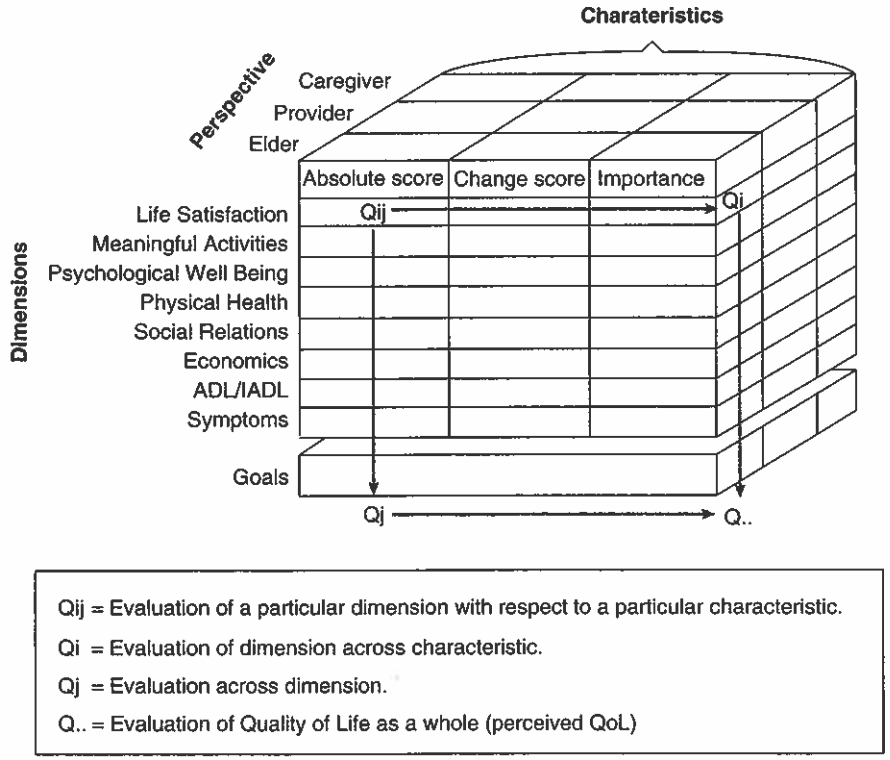

Figure 1 Conceptual Model for Evaluating Quality of Life in Older Adults

Note: ADL/IADL = activities of daily living/instrumental activities of daily living.

assist him or her with filling out the questionnaire. A caregiver can complete the WQLI on behalf of an incapacitated older adult. Quality of life assessments can then be used to monitor the course of chronic illness and the impact of medical treatment and other services. By examining separate domains of quality of life with a multidimensional instrument such as this, the interrelationship among physical, psychological, and social dimensions can be explored and better understood. Future research should focus on the complex interrelationships among quality of life, illness severity, and health outcomes in older adults

—Marion A. Becker and Ezra Ochshorn

See also Expectations Regarding Aging; Positive Attitudes and Health; Social Networks and Social Support; Successful Aging

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