Quality of Life of Healthy Older People: Residential Setting and Social Comparison Processes

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This study focussed on perceptions of quality of life (QoL) among people aged 65 or over, in good health, living in one London Borough. It reveals the impact that both type of residence and the individual's social comparison strategy leave on QoL. Those taking part in the research were classified by their type of residence and standard measures of QoL and health status were used.

Summary of key findings

- The most important factors in determining a perceived good QoL were the individual's perception of their health, freedom from depression, personal optimism, well-retained cognitive abilities and aspects of the social environment.

- The common themes concerning their QoL, mentioned by participants as important, were issues related to their family, their health, and to the conditions associated with their home.

- With respect to residence, those who were living with a partner tended to report the highest QoL; those in residential homes, irrespective of their health or disability, reported the poorest quality of life.

- Depression leads to a lower perception of QoL, rather than a poor QoL leading to depression.

- The dominant social comparison strategy was downward contrast (to consider yourself unlike those who are 'worse off') and this appears to be an adaptive and functional approach which enhances perceived QoL.

- Reports of perceptions of QoL are heavily influenced by the nature of the question which is asked.

What older people consider important to their QoL

There were marked individual differences in the topics which participants mentioned as relevant to their QoL. A given issue may concern only a minority, but be very important to that minority (and a good example is 'transport', particularly if transport is inadequate). However, those which were most frequently mentioned, and which were accorded a high importance, were family, health, and home. To these can be added emotional well-being, independence (freedom of choice) and mobility. To some, where it was relevant, a partner and companionship were of great importance. This accords with the finding that social environment, (which included aspects of home, safety, finances, services, leisure, environment and transport) was the most important single factor directly predicting individual quality of life.

Type of residence

Residential status had an effect upon the QoL reported. The clearest effect was that those in residential homes tended to report a poorer QoL. Although they were also older, less cognitively able and reported more health problems, health problems did not account for this relationship. Among the other residential categories, there was a
complex pattern of results, but a clear tendency for living with a partner, companion or family to be associated with higher reported levels of QoL. Residential setting proved to have complex effects, partly because we discovered that what appeared to be homogeneous groupings did not prove to be so. For example, those classified as living in 'sheltered housing' could be either relatively affluent older individuals who had moved by choice into privately owned developments, or those who were now living in local authority rented accommodation and needed a minor degree of care and supervision. There were, however, two clear findings. The first was that those who were living with their partner tended to report the highest QoL; while, secondly, it was clearly the case that those in residential homes, irrespective of their health or disability, reported the poorest quality of life.

The role of disability
Disability was associated with other health variables, as might be expected, but was also associated with cognitive variables, a greater degree of physical disability being associated with lower mental ability. More disabled individuals were likely to be in sheltered or residential accommodation, and more likely to be depressed and to have lower self-esteem. Probably as a result of these mediating factors, increased disability was reflected in lower QoL judgements on certain measures. Socio-economic status, although contributing to QoL, possibly through general ability or education, had no direct relationship to QoL scores.

The role of cognitive ability and psychological health
Despite their 'healthy' physical and general cognitive status, about 15 per cent of participants had deficits in autobiographical memory for incidents and 16 per cent deficits for personal semantic information. On QoL measures, individuals who had difficulty in recalling personal semantic information from their past perceived their QoL as higher; they also perceived their current health as better, and there was a tendency for them to be less depressed. It seems reasonable to hypothesise that a failure to recall the past may sometimes be beneficial, mitigating against adverse comparisons with QoL in earlier periods of life.

Those reporting a lower QoL also performed at a lower level on almost all measures of mental abilities. Is this effect simply secondary to depression? Depression was clearly a potent factor in explaining differences in mental ability and when it is taken into account many of the effects disappear. However, depression does not entirely account for this relationship as, after the effect of depression is extracted, a relationship remains between QoL scores and mental ability scores. Age was also a factor in these relationships, but although advancing age and depression were factors reducing perceived QoL, there is a relationship between lower levels of cognitive function and lower reported QoL which is independent of these factors.

Psychosocial variables were, however, the strongest predictors of QoL reports. Participants who were satisfied with their living arrangements, those who reported that their health was good, and those who believed that they had the ability to respond to and control environmental demands and challenges (higher self-efficacy) reported higher levels of QoL.

The use of social comparison strategies in QoL judgements
Considering the use of social comparisons, strategies which might be expected to be associated with higher QoL (positive strategies: upward identification – seeing yourself as similar to those who are 'better off'; downward contrast – seeing yourself as unlike those who are 'worse off'; these are contrasted with negative strategies: upward contrast – seeing yourself as unlike those who are 'better off', and downward identification – seeing yourself as like those who are 'worse off') were found to be used by those reporting a higher QoL. Downward contrast accounted for 78 per cent of strategies. No other strategy accounted for more than 7 per cent, and this may in part explain the generally high QoL reported by participants. There were differences among the residential groups in the strategies which they adopted. Those living with a partner, companion or family and those living alone for less than 10 years were more likely to adopt positive strategies, while those living alone for more than 10 years used significantly fewer positive strategies. However, the almost universal strategy among our healthy older participants was
to employ downward contrast comparisons: to focus on those who they perceived to be worse off than themselves, and to evaluate themselves as having a better QoL by comparison (‘A lot of people here are a lot worse off than me’ and ‘[You] gain a heightened awareness of all those who are in a worse position’ were two typical comments from our participants). This was the dominant strategy to such a degree that it is difficult to know whether alternative strategies may be more or less effective in promoting a sense of a good QoL, but the evidence points to the fact that this is an adaptive and functional approach which enhances the generally high levels of QoL which our participants reported. 'Counting your blessings' may be a very adaptive thing to do.

Modelling the factors that determine individual judgements of QoL

Previous research on the relationship between depression and health in the QoL of older adults does not have a clear conclusion. Modelling of all the data taken together addresses this issue. The first approach has been to construct a simple unidirectional model. In this model the WHOQOL-BREF general health index was the single best predictor of depression as an outcome variable, with 44 per cent predictive power. In order of magnitude, significant determinants of this predictor were psychological, physical health, environmental and cognitive factors. The evidence demonstrates the relationships among individual status factors, QoL perceptions, and depression, but gives no clues as to the causal direction of these relationships.

A causal interpretation can be achieved by a structural equation model, which was the second approach (see Figure 1). The best model we have identified clearly suggests that depression is antecedent in influencing QoL judgements; depression causes QoL to be perceived as poorer, rather than being a result of a poor QoL. The model also demonstrates that in addition to depression, perceived health, the social environment, and cognitive ability have an effect upon QoL. Health concerns are shown to be the primary factor which affects depression and the social environment. Depression has a direct effect on QoL, but also a further effect through its influence upon cognitive function. Of the three factors directly determining QoL in the model (the social environment, depression and cognitive ability) social environment is the most important.

**Measuring and predicting QoL**

The study has established that it is possible to assess individual QoL perceptions in healthy older people and that, while there are common features among different assessments, the exact determinants depend upon the measure being employed. Judgements of QoL depend heavily on exactly which question is asked. As is generally recognised, QoL is a multidimensional concept which individuals invest with personal meanings which are inevitably reflected within the semiotic context created by investigators.

Analysis of the measures which concurrently predicted QoL as assessed by the principal measure of individual-centred QoL (SEIQoL-DW), showed that psychomotor speed, the tendency to make upward identifications in social comparison, socio-economic status, and self-efficacy were significant predictors. Considering only psychosocial variables, and excluding other QoL measures, allowed 46 per cent of the variance in QoL scores at the final interview to be predicted by positive optimism, a self-rating of general health, the number of health problems, and two aspects of autobiographical memory.

A variety of measures is clearly valuable in assessing QoL. These analyses demonstrate that, taking account of the very wide range of factors which influence QoL perceptions, a surprisingly good prediction can be obtained on the basis of a small number of psychosocial factors. The common finding is that a higher perceived QoL is associated with higher socio-economic status, a perception of good health, lower levels of depression, personal optimism, and better cognitive function in terms of psychomotor speed and memory, especially autobiographical memory. Some clear generalisations have emerged from our data. The most important factors in determining a perceived good QoL are the individual's perception of their own good health (even given that all our participants regarded themselves as 'healthy'), freedom from depression, personal optimism, and well-retained cognitive abilities. Depression plays a central role in determining QoL judgements, itself dependent upon a variety of other psychosocial variables, and
most importantly our data support the proposition that depression in older adults leads to a perception of poor QoL, rather than a pre-existing poor QoL resulting in depressed mood.

**About the study**

Participants, living in the London Borough of Wandsworth, who were 65 years or older and considered themselves to be in good health, were recruited. Two hundred and fifty volunteers were invited to a selection interview on the basis of which inclusion in the study was determined. Exclusion criteria were a significant deficit in cognitive function (below the 95th percentile on the Dementia Rating Scale [DRS]), significant physical disability (EDSS score above 4.0) or acute health problems. Of the 250 interviewed, 193 were selected (46 failed the DRS, 10 declined to participate further, and one died), being 134 women and 59 men. The ages of participants ranged from 65 to 98 years, with a mean of 77 years. Participants were assigned to one of five residential categories: Living alone for more than 10 years (N = 40); Living alone for less than 10 years (N = 44); Living with partner, companion or family (N = 37); Living in sheltered housing (N = 42); Living in a residential home (N = 30).

Selected participants were invited to three main assessment interviews, which essentially included the same measures, at eight monthly intervals (range 28 to 45 weeks, mean 33 weeks). There was inevitably attrition across the study, and the numbers completing the second and third main interviews were 159 (82.4 per cent) and 143 (74.1 per cent) respectively.

The measures employed were [* selection interview only]:

**Cognitive Status:** * Autobiographical Memory; * Dementia Rating Scale; KASCA; Digit Span

**Social and Demographic Status:** * Demographic information; * Socio-economic Classification

**Social Environment:** Residential status; Satisfaction with living arrangements; Significant life events; Social group and support networks

**Physical Health Status:** Current state of physical health; EDSS; Self-Assessed Health Status

**Psychological Status:** GSES; GDS; LOT; RSES

**Quality of Life:** Ratings of QoL; SEIQoL-DW; WHO-QOL-BREF

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