

Exploring the construction of quality of life in older people

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I dedicate this study to:

My late father **Marthinus de Jager (1956-1998)**,

who will always remain the most remarkable person I ever knew

and his mother,

my grandmother, **Martha Maria Susanna De Jager (1929)**,

whose (later) life story inspired this inquiry.

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Through **God** only, do I live, move and have my being. Soli deo Gloria.

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SUMMARY

Ageing populations and the unique challenges they pose are characteristic of the accelerating demographic transition evident in both developed and developing countries. In South Africa the elderly population is also increasing dramatically. There is a disproportionate distribution of older persons per ethnic group, with white older people representing the largest group of older South Africans (21%, proportional to ethnic group). The influx of the baby boomer generation will inevitably lead to an exponential increase in the numbers of white older people within the next two decades.

Regardless of integration policies in post-apartheid South Africa, 90% of all residential care facilities are still occupied solely by white older people. Such facilities are described as buildings or other structures used primarily for the purposes of providing accommodation and of providing a 24-hour service to older persons. The increasingly larger segment of white older people holds considerable implications for the future of these facilities since more individuals will turn to this living arrangement. The Older Persons Act of South Africa was inaugurated by the government in 2006 and its key objectives are aligned with the recommendations of the Madrid International Plan of Action on Ageing (2002). Amongst many other objectives, the Older Persons Act emphasises practices that enhance the well-being and quality of life (QoL) of all older persons. However, the reigning circumstances in most residential care facilities have been described as challenging. A national audit of residential care facilities in 2010 indicated a need for psychosocial interventions since the QoL of residents was found to be undefined and unspecific.

The purpose of the study was to explore the construction of QoL, from the perspective of the older people living in residential care facilities. A purposive sample of 54 participants (male,

n=10; female, n=44) with ages ranging between 62 and 95 years was drawn. The participants were able to communicate congruently and understood the research purpose. Participants resided in four similar facilities situated in urban areas in two South African provinces. A multiple-context inquiry was conducted to gather rich data and collateral information. The study made use of interviews, focus groups, journals, and the Mmogo-method[®] to collect qualitative data. Interpretative Phenomenological Analysis (IPA) and visual analysis methods were used to analyse the data. Interactive Qualitative Analysis (IQA) was conducted with 19 participants, resulting in a conceptual model of QoL. Member-checking was performed by the participants. Ethical approval was granted by the Ethics Committee of the North-West University (Potchefstroom Campus), as part of a larger project, namely “An exploration of enabling contexts (05K14)”.

The findings revealed that the nature of QoL is informed by spiritual worldviews, interpersonal contexts and the maintained ability of older people to regulate aspects of their own lives. The nature of QoL was also revealed as transitional throughout the ageing process and that the dimensions of QoL may be found on a continuum. Six domains were elicited in the construction of QoL, namely spirituality, health, relationships, meaningfulness, autonomy and sense of place. Each domain presented with certain contributors and inhibitors influencing the older person’s ability to experience QoL. Findings revealed the strengths of older people to deal with adversities associated with later life. The inhibitors of QoL are emphasised for the attention of policy makers, the managers of residential care facilities, care givers and family members.

The study provided insight into the causal influences between the domains of QoL. A conceptual model with systemic properties is proposed. The theoretical implications of this systems model are that QoL domains are mutually informing and exercise a particular

influence on the relational states of older people. It is hoped that new knowledge in the area of QoL might direct future research efforts and put resources channeled to residential care facilities to better use.

Keywords: Quality of life; older persons; residential care facility; QoL contributors; QoL inhibitors; QoL domains; Interactive Qualitative Analysis; Mmogo-method[®]

OPSOMMING

Verouderende bevolkings en die unieke uitdagings wat daarmee gepaard gaan, is kenmerkend van die versnellende demografiese oorgang wat in ontwikkelde sowel as ontwikkelende lande duidelik is. In Suid-Afrika vermeerder die bejaarde bevolking ook dramaties. Daar is 'n oneweredige verspreiding van ouer persone per etniese groep, met wit ouer persone wat die grootste groep van ouer Suid-Afrikans verteenwoordig (21%, proporsioneel tot etniese groep). Binne die volgende twee dekades sal die instroming van die “Baby Boomer”-generasie onvermydelik tot 'n eksponensiële styging in die getalle van wit ouer mense lei.

Ongeag die integrasiebeleide in postapartheid-Suid-Afrika, word 90% van alle residensiële sorgfasiliteite steeds slegs deur wit ouer mense bewoon. Hierdie fasiliteite word beskryf as geboue of ander strukture wat hoofsaaklik gebruik word om verblyf en 'n 24-uur-diens aan ouer persone te verskaf. Die toenemende segment van wit ouer mense hou beduidende implikasies vir die toekoms van hierdie fasiliteite in aangesien meer individue hulle na hierdie tipe verblyf sal wend. Die Wet op Ouer Persone is in 2006 deur die regering in gebruik geneem en die hoofdoelmerke daarvan is in lyn met die aanbevelings van die Madrid Internasionale Plan van Aksie vir Ouer Persone (2002). Die Wet op Ouer Persone beklemtoon onder andere praktyke wat die welsyn en lewenskwaliteit van alle ouer persone bevorder. Die heersende omstandighede in die meeste residensiële sorgfasiliteite word egter as 'n uitdaging beskryf. 'n Nasionale oudit van residensiële sorgfasiliteite in 2010 het 'n behoefte aan psigososiale intervensies getoon aangesien die lewenskwaliteit van inwoners as ongedefinieerd en onspesifiek bevind is.

Die doel van hierdie studie is om die konstruksie van lewenskwaliteit te verken vanuit die perspektief van die ouer mense wat in residensiële sorgfasiliteite bly. 'n Doelgerigte

steekproef van 54 deelnemers (manlik, n=10; vroulik, n=44) tussen die ouderdomme van 62 en 95 is getrek. Die deelnemers was in staat om samehangend te kommunikeer en het die navorsingsdoel verstaan. Deelnemers het in vier soortgelyke fasiliteite in stedelike gebiede in twee Suid-Afrikaanse provinsies gewoon. 'n Veelkonteks-ondersoek is gedoen om ryk data en kollaterale inligting te versamel. Die studie het van onderhoude, fokusgroepe, joernale en die Mmogo-metode[®] gebruik gemaak om kwalitatiewe data te versamel. Interpretatiewe fenomenologiese analise (IFA) en visuele analisemetodes is aangewend om die data te analiseer. Interaktiewe kwalitatiewe analise (IKA) is met 19 deelnemers gedoen, waaruit 'n konseptuele model van lewenskwaliteit gespruit het. Die bevindings is met die gebruik van IKA deur die deelnemers geverifieer. Etiese goedkeuring is deur die Etiekkomitee van die Noordwes-Universiteit (Potchefstroom-kampus) verleen as deel van 'n groter projek, naamlik “An exploration of enabling contexts (05K14)”.

Die bevindinge het onthul dat die aard van lewenskwaliteit beïnvloed word deur spirituele wêreldbeskouings, interpersoonlike kontekste en die volgehoue vermoë van ouer persone om aspekte van hulle eie lewens te beheer. Dit het ook geblyk dat lewenskwaliteit onderhewig is aan verandering soos wat die persoon ouer word en dat di dimensies van lewenskwaliteit op 'n kontinuum lê. Ses domeine het in die konstruksie van lewenskwaliteit na vore gekom, naamlik spiritualiteit, gesondheid, verhoudings, betekenisvolheid, outonomie, en 'n gevoel van plek. Elke domein het sekere bydraende en stremmende faktore getoon wat die ouer persoon se kapasiteit om lewenskwaliteit te ervaar, beïnvloed. Ouer persone se vermoëns om die uitdagings te hanteer wat met die latere lewe vereenselwig word, is onthul. Klem word gelê op die stremmende faktore van lewenskwaliteit om dit onder die aandag van beleidmakers, die bestuurders van residensiële sorgfasiliteite, versorgers en gesinslede te bring.

Die studie bied insig in die kousale invloede tussen die domeine van lewenskwaliteit. 'n Konseptuele model met sistemiese kenmerke word voorgelê. Die teoretiese implikasies van hierdie sisteemmodel is dat die domeine van lewenskwaliteit mekaar wedersyds beïnvloed en 'n spesifieke invloed op die toestand van ouer mense se verhoudings uitoefen. Die hoop word uitgespreek dat nuwe kennis op die gebied van lewenskwaliteit rigtinggewend kan wees vir toekomstige navorsingspogings en dat die hulpbronne wat na residensiële sorgfasiliteite gekanaliseer word, beter benut word.

Sleutelwoorde: Lewenskwaliteit; ouer persone; residensiële sorgfasiliteit; bydraende faktore tot lewenskwaliteit; stremmende faktore van lewenskwaliteit; domeine van lewenskwaliteit; interaktiewe kwalitatiewe analise; Mmogo-metode[®]

PREFACE

PhD (Psychology) in article format

- The thesis is presented in article format as indicated in rule A.14.4.2 of the yearbook of the North-West University, Potchefstroom Campus.
- For purposes of examination the articles are presented as part of a single document consisting of three parts that include an introduction, three articles and the conclusions and recommendations.
- A reference list will be provided at the end of each chapter.
- The first author was primarily responsible for all research procedures and stages in each manuscript, including the literature searches, data collection, thematic and visual analysis, interpretation of results and writing of the manuscripts.
- In all the manuscripts the promoter is named as co-author and in the third article Prof. Karel Botha (School of Psychosocial Sciences at the North-West University) shares authorship.
- The three articles are formatted according to the requested guidelines for authors. The articles will be submitted to different journals as relevant to the topic. The author guidelines are provided in the Appendix. The articles will be shortened before submission.
- Qualitative data were collected in Afrikaans. All quotations in the manuscript were directly translated into English.
- Please take note of the repetitive use and mentioning of certain research procedures in the consecutive chapters. Literature sources of key importance to the field of quality of life of older people may appear recurrently to ground each article.

- References are formatted according to the American Psychology Association (APA) guidelines (6th edition) throughout the document. Where in-text references refer to three to five authors, the names of all the authors are listed the first time the reference appears in each of the four articles, as each article is viewed as a separate unit.
- Process documents, examples of raw data and visual images that relate to the research process as well as the results of the Turnitin software are presented on the enclosed CD.
- A letter of permission from the study leader to submit the articles for examination purposes is included on p. xii.

LETTER OF PERMISSION

I, the promoter, declare that the input and effort of Lisanlé van Biljon in writing these articles, reflects the research conducted by her. I hereby grant permission that she may submit these articles for examination purposes in fulfilment of the requirements for the degree Doctor Philosophiae in Psychology.

Prof. Vera Roos

Promoter

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CHAPTER 1

INTRODUCTION

CONTEXTUALISING THE STUDY

The demographic transition and permanent shift to an older age structure, also known as primary population ageing, is a consequence of long-term downward trends in fertility alongside gains in average life expectancy (Grundy & Tomassini, 2005). Since the Second World War, industrialised nations have experienced a rapid increase in life expectancy. In recent years those in developed countries who have survived to age 60 years can expect to live another 18 years when they are male, and females can expect an additional 21 years (Stuart-Hamilton, 2006). Furthermore, low birth rates have accentuated the demographic shift by reducing the number of new individuals entering the younger age groups. Data compiled by the United Nations Population Division show that the number of persons aged 60 years and over is expected to triple by 2050. By then it is expected that more than 1 in every 5 people will be aged 60 years or over (United Nations, 2007). In absolute terms 2 billion people will be older than 60 years by 2050 and for the first time in human history the population of older persons will be larger than the child population (0-14 years) (Population Reference Bureau, 2012). In addition, the composition of the older population in itself is ageing, with the “oldest old” segment, namely people aged 80 and over, representing 13% of the population aged 60 years and over. Yet, projections show that by 2050 this proportion will have grown to some 20% of those aged 60 years and above (Population Reference Bureau, 2012).

Population Ageing

Research by Joubert and Bradshaw (2006) has indicated that population ageing was formerly experienced by the more developed countries as a gradual process, while it is now experienced to happen more rapidly by developing countries, making it a global phenomenon. Developing countries conform to the same demographic trends and are

becoming old even faster than developed countries. According to the projections by the United Nations Population Division, the old-age dependency ratio could more than double in 50 years in some developing countries, whereas in developed countries it has doubled over a range of 150 to 200 years (United Nations, 2007). In developing regions, the number of persons currently aged 60 years or over is expected to increase nearly fourfold, from 2005 to 2050. Not only do these numbers demand attention, but also the variation in circumstances of the ageing population in many developing countries. Societal shifts in living arrangements and changing family structures will have a vast impact on older people in these countries (Aboderin, 2005).

Older people in South Africa. South Africa has one of the most rapidly ageing populations in Africa (Westaway, Olorunju, & Rai, 2007). According to the Population Reference Bureau (2012), 86% of all older persons in Southern Africa reside in South Africa. The current population figures of South Africa give the impression of an expanding young black population and an ageing and shrinking white population (see Figure 1). The age structure for black South Africans has a broad base and narrow apex, while for white South Africans it has a narrow base and broad apex. According to the 2011 national census, the South African population increased from 40.5 million in 1996 to 51.7 million in 2011, of whom 41 million are black, 4.6 million are coloured, 4.6 million are white and 1.5 million are Asian/Indian. According to the figures above, more than three quarters of the South African population are African, representing 79.2% of the population, while the share of the Indian/Asian population has remained constant. The percentage of the white population has declined slightly from 10.9% in 1996 to 8.7% in 2011 (Statistics South Africa, 2011).

Life expectancy. The 2011 national census indicated life expectancy as 54 years for men and 59 years for women (Statistics South Africa, 2011). These estimates explicitly take into account the effects of excess mortality due to HIV as this scourge results in lower life

expectancy, higher infant mortality, lower population growth rates, higher death rates and more changes in the distribution of the population by age and sex than would normally be expected. The life expectancy figures of white South Africans as an ethnic sub-population are far above the national projected expectancies (Timaheus, Dorrington, Bradshaw, & Nannan, 2001). Stuart-Hamilton (2006) referred to the Roseto effect as described by Egolf which demonstrates how life expectancy can differ within the same society simply by looking at the socio-economic status of the group and the lifestyle they lead.

Closer investigation (see Figure 1) of the age structure of older South Africans per ethnic group revealed that only 5.9% of black South Africans are aged 60 years and above; 7.3% of coloured South Africans are older than 60 years; and 10% of Asian/Indian South Africans are aged 60 years and above. When looking at the latest estimates (2011), older white South Africans account for a vast 21% of the entire white population. Within the next decade this figure will extrapolate to 30%, according to Statistics South Africa (2011), mainly due to low fertility rates, migration patterns and because of the baby boomer influx (rise in the birth rate in industrialised countries when the Second World War ended, i.e. a larger birth cohort followed from 1945) (Biggs, Phillipson, Leach, & Money, 2007). For this reason the remainder of this inquiry will focus on older white South Africans as the study's population.

Age	African			Coloured			Indian/Asian			White			South Africa		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	2 222 310	2 186 449	4 408 759	207 417	204 983	412 400	50 709	49 426	100 135	136 469	131 765	268 234	2 616 905	2 572 623	5 189 528
5-9	2 278 419	2 243 240	4 521 659	211 308	209 415	420 723	46 064	45 046	91 110	137 992	132 565	270 557	2 673 783	2 630 266	5 304 049
10-14	2 273 433	2 242 791	4 516 224	210 035	208 103	418 138	47 896	47 020	94 916	147 828	141 585	289 413	2 679 192	2 639 499	5 318 691
15-19	2 184 734	2 163 195	4 347 929	206 987	205 394	412 381	52 789	52 189	104 978	158 767	151 393	310 160	2 603 277	2 572 171	5 175 448
20-24	2 052 918	2 035 857	4 088 775	194 879	194 522	389 401	56 632	56 427	113 059	157 556	151 584	309 140	2 461 985	2 438 390	4 900 375
25-29	1 858 498	1 947 992	3 806 490	180 483	189 113	369 596	59 991	59 411	119 402	150 937	151 751	302 688	2 249 909	2 348 267	4 598 176
30-34	1 639 101	1 618 682	3 257 783	182 233	195 421	377 654	56 360	56 447	112 807	143 492	149 015	292 507	2 021 186	2 019 565	4 040 751
35-39	1 374 876	1 457 977	2 832 853	182 986	200 661	383 647	47 190	48 075	95 265	139 663	148 739	288 402	1 744 715	1 855 452	3 600 167
40-44	858 347	1 014 100	1 872 447	155 003	174 301	329 304	42 067	43 304	85 371	159 180	166 630	325 810	1 214 597	1 398 335	2 612 932
45-49	678 158	875 485	1 553 643	132 697	151 767	284 464	38 927	40 707	79 634	160 491	166 350	326 841	1 010 273	1 234 309	2 244 582
50-54	601 060	800 234	1 401 294	107 752	125 713	233 465	35 198	37 389	72 587	161 132	170 053	331 185	905 142	1 133 389	2 038 531
55-59	483 709	639 392	1 123 101	79 635	96 343	175 978	30 599	33 621	64 220	151 106	158 864	309 970	745 049	928 220	1 673 269
60-64	359 119	509 933	869 052	55 115	72 142	127 257	24 515	28 554	53 069	144 052	157 873	301 925	582 801	768 502	1 351 303
65-69	255 558	377 825	633 383	35 906	47 323	83 229	16 581	19 868	36 449	111 107	124 531	235 638	419 152	569 547	988 699
70-74	176 198	282 580	458 778	23 833	35 311	59 144	10 729	14 103	24 832	78 424	93 937	172 361	289 184	425 931	715 115
75-79	105 619	190 318	295 937	13 777	23 329	37 106	6 162	9 089	15 251	47 300	65 381	112 681	172 858	288 117	460 975
80+	69 981	148 187	218 168	8 736	17 167	25 903	4 281	7 501	11 782	42 030	76 283	118 313	125 028	249 138	374 166
Total	19 472 038	20 734 237	40 206 275	2 188 782	2 351 008	4 539 790	626 690	648 177	1 274 867	2 227 526	2 338 299	4 565 825	24 515 036	26 071 721	50 586 757
	5.9%			7.3%			10%			21%					

Figure 1. Population estimates (> 60 years highlighted, Statistics South Africa, 2011)

Gender effects. Gender effects for the white group of older South Africans seems to comply with ageing trends mentioned in other developed and developing countries in which women tend to outlive men (Kalache, Barreto, & Keller, 2005). The balance of men and women is roughly equal until about 45 years. Thereafter men die at a faster rate, so that by 80 years the ratio has moved to two/three women for every man in South Africa. Consequently, there were more older women in the present study's sample population than older men.

Migration. The South African Institute of Race Relations (2006) stated in their annual report that 841 000 white South Africans had left the country in the period ranging from 1995-2005. This analysis was conducted by comparing the figures of Stats SA household surveys from 1995 and 2005. Most of these migrants are young adults and young families – older people rarely migrate with their children. The older generations remain in South Africa and, for some, there is very little evidence of filial piety apart from financial support.

Generational composition and social roles. The population under investigation represents people from more than one generation. The traditionalists (born between 1918-1945)¹ are known for their rigid patriarchic structure, quality workmanship and organised religious systems (Codrington & Grant-Marshall, 2005; Marcoen, 2005). Women were subdued by men and in most cases assumed the position of homemaker and care giver. Worldviews for both generations are very conservative (Hartman-Stein & Potkanowicz, 2003). The baby boomer generation (born between 1946-1966)² brought along a revolution in attitudes and social norms (Alwin, McCammon, & Hofer, 2006; Alwin, 2007). Sex before marriage became acceptable, women entered the workforce, men were encouraged to share the housework and child care, and divorce became an acceptable alternative to living in an unhappy marriage (Belsky, 1999). Baby boomers from the white population in South Africa have conformed to many of these changes in social norms. The implications of this for their later life calls for attention. This cohort (close to 1 million of the 4.6 million white South Africans) had fewer children than their parents and divorce is a common phenomenon. Thus, fewer relatives (spouses and children) will be available to take care of these people when they are old and alternate means of care will need to be established. Divorced men are especially vulnerable. A study by Webster and Hertzog (1995) indicated that when fathers leave the family when children are young, the price is often isolation from children in old age. Divorced women and single mothers are not likely to have adequate savings or pension funds to provide for old age and are more likely to be socially vulnerable (O’Rand, 1996).

Socio-political influences. Older white South Africans were born either before or within the period of highly influential political occurrences which rooted them in their belief systems and conduct. Already in 1948, the National Party was voted into power and instituted a policy of apartheid - the separate development of the races - which favoured the white

¹ Dates may vary between authors and sources.

² Dates may vary between authors and sources.

minority over the black majority. This continued until 1978 and from there onwards South Africa experienced a decade of crisis under the apartheid regime (Thompson, 2000). Internal protests and uprising, as well as boycotts by some nations led to the first multi-racial elections in 1994 which brought an end to apartheid and steered a political transition to the 'New' South Africa under an ANC-led government. Since then South Africa has struggled to address the widespread imbalances between racial groups, especially pertaining to education, employment equity, health care and adequate housing (Thompson, 2000).

Living arrangements of older people. Older people are often dependent on others for support and care. With the swift increase in older persons, an increasing demand for long-term care has arisen since there are more older people to look after, and fewer people to look after them (Van der Walt, 2011). For the purpose of this research, long-term living arrangements will be referred to as residential care facilities. According to South African legislation, such a facility is described as “a building or other structure used primarily for the purposes of providing accommodation and of providing 24-hour service to older persons” (Older Persons Act, No. 13 of 2006, p. 6, Department of Social Development, 2006). The availability of residential care facilities for older persons should also be seen against the backdrop of facilities only being available for white older people prior to 1994. Under the apartheid rule, facilities were made available only to white older persons – the members of other racial groups did not have access to such facilities.

However, in post-apartheid South Africa these facilities were opened up to all South Africans regardless of race or colour (Department of Social Development, 2010). Nonetheless, an audit by the Department of Social Development found that the majority of facilities (79%) are concentrated in metropolitan formal areas or small urban formal areas. Only 5% are in informal or squatter areas, while 16% are in rural areas, having the effect that the majority of these facilities are occupied by white older people (Department of Social

Development, 2010). Furthermore, the distribution of old age residential care facilities is disproportionate in the wealthier provinces of Gauteng and the Western Cape, with a distinct lack of facilities in poorer provinces such as Limpopo, the Eastern Cape and the Free State.

Policies on Ageing

In light of the projected increases in the older population, numerous developed countries have long since focused on the challenges of ageing for some time. From as early as 1940, shortly after the inception of the United Nations (UN), potential challenges were addressed in policies for older people (Zelenev, 2006). In the 1970s UN ageing policies started to debate the economic and social consequences of ageing. At that point in time other factors such as health, well-being and developmental issues did not receive as much attention. As a result, the General Assembly decided in 1978 to convene the First World Assembly devoted to the more general issues of ageing as a step toward formulating an international action plan on ageing that would address the needs and demands of older persons by informing governments on how to create ageing policies that would meet these demands.

In 1982 the United Nations convened the First World Assembly on Ageing in Vienna to discuss the ‘population ageing’ phenomenon and its implications. The Assembly compelled policy makers to re-evaluate existing policies and resulted in a plan of action on ageing. The Vienna plan addressed issues of health and nutrition, housing and environment, the protection of elderly consumers, family, social welfare, well-being, income security, employment and related areas, as well as issues of research, data collection and analysis, and education and training. The well-being of older people was mentioned for the first time in policy but the actual implementation thereof in macro- and micro environments remained fruitless. The plan centered on responding to the specific needs of older persons and the implications of the ageing population for socio-economic policy, and more specifically the

burden it would place on available resources (Madrid International Plan of Action on Ageing, 2008).

The year 1999 was designated as the International Year of Older Persons which led to international awareness of critical matters pertaining to older persons (their current situation, the prospects of lifelong individual development, the state of multigenerational relationships, and development in ageing populations). This inspired preparations for the Second World Assembly on Ageing, held three years later in Madrid. “Active ageing” was a guiding concept in the preparations in bringing together agendas for optimising opportunities for health, participation and security in order to enhance quality of life (QoL) as people age (WHO, 2002).

In 2002 the United Nations convened the Second World Assembly on Ageing at which the Madrid International Plan of Action on Ageing (MIPAA) was drafted and adopted. This plan sought to meet the challenges associated with ageing populations. Focus areas were identified as: the development of older persons, advancing health and well-being into old age and ensuring enabling and supportive environments. It was further recommended that priority be given to developing countries as the most rapid ageing will occur in the first half of the century for these countries.

Especially due to the diversity in living conditions, South Africa is simultaneously regarded as a developed and as a developing country rolled into one (Møller, 2004). The South African government responded to the MIPAA and aligned the main objectives for older persons in national legislation in the Older Persons Act, as follows (Department of Social Development, 2006):

- To ensure that older persons remain in the community as long as they can,

- To maintain and promote the status, well-being and quality of life, safety and security of older persons,
- To recognise the skill and wisdom of older persons,
- To promote participation of older persons in the community so as to promote them as people.

For the purpose of this study, the focus is on the promotion of the QoL of older people, stipulated as one of the main objectives in the act.

A Synopsis of QoL

From the preceding section it is evident that international and national policies emphasise quality of life (QoL) and well-being as two major challenges and objectives for older people. QoL and well-being are often used as interchangeable constructs which often lead to confusion (Jeffres & Dobos, 1995; Westaway et al., 2007). Well-being is more often used when reference is made to non-physical aspects of human functioning such as emotional well-being or psychological well-being (Wissing & Van der Lingen, 2003). ‘Well-being’ is a concept open for subjective interpretation within the context in which it is used. ‘Quality of Life’ on the other hand is used as a concrete construct that indicates inequalities in health and social exclusion in a range of disciplines (Gaibie & Davids, 2011; Gilhooly, Gilhooly, & Bowling, 2005).

Although QoL is used in various disciplines, it is still a general description that includes the physical and non-physical dimensions of life in general (Skelton & Dinan-Young, 2008). For example, QoL is used in relation to living environments, available time, health, income and social life. In terms of the non-physical, it is used in relation to the self and others and is described as satisfaction with the self, with one’s partners, family, friends, life and spirituality (Flanagan, 1982; Westaway, 2006).

Defining QoL. Definitions of QoL reveal not only the complexity of the concept, but very real differences in opinion on the nature of QoL. According to Gilhooly et al. (2005), some researchers define the concept as an individual experience, such as Mendola and Pelligrini (1979) who stated that QoL is the individual's achievement of a satisfactory social situation within the limits of perceived physical capacity. Likewise, Shin and Johnson (1978) defined QoL as the possession of resources necessary to the satisfaction of individual needs, wants and desires, participation in activities enabling personal development and self-actualisation and satisfactory comparison between oneself and others. Others define QoL more in terms of broader societal trends. For instance, Møller (2007) defined QoL as how well a country's citizens live. Additionally, individual and societal aspects are also combined to define the phenomenon, such as is found in the work of Higgs (2007) who uses the term everyday quality of life (EQL). EQL is defined as a function of the resources and external factors that affect how that person is able to live as well as the internal choices that a person makes along with their effects; how satisfied an individual is; and the perceived level of subjective well-being or happiness.

An all-encompassing definition by Veenhoven (2000) proposed that QoL takes into account the livability of an environment, the life-ability of a person, the utility of life and the appreciation of life measured against life changes. The definition of the World Health Organization (WHOQOL, 1993) was adopted as an operational definition for this study. This definition proposes that QoL includes individuals' perception of their position in life in the context of the culture and value systems in which they live in relation to their goals.

Theories of QoL. QoL-theories tend to be divided in two categories: the bottom-up or the top-down model. The bottom-up model states that one's satisfaction with the various domains in one's life determines overall well-being and happiness (Møller, 2004). This theory has traditionally dominated QoL research. The newer top-down model, also known as

the Multiple Discrepancy Theory holds that one's overall satisfaction with life is indicative of how one feels about the various aspects of life (Møller, 2004; Gaibie & Davids, 2011).

Measurement of QoL. With regards to the measurement of QoL, a popular trend in research concerned with QoL is to be domain specific. Ample measures are available in economic and health-orientated disciplines (Ball & Chernova, 2008; Brown et al., 2003; Chyun et al., 2006; Hayo & Seifert, 2003; Jones, Voaklander, Johnston, & Suarez-Almazor, 2001; Revicki, 1989). Primarily these two traditions have influenced the way we perceive QoL (Daatland, 2005). Economic enquiries on QoL tend to be focused on living standards as measured by access to income and material goods. Thus, QoL is measured indirectly (Gilhooly et al., 2005; Hayo & Seifert, 2003). Health or medical enquiries measure QoL directly and focus on the personal and case-specific health related experiences (Gilhooly et al., 2005; Revicki, 1989).

A review by Hambleton, Keeling and McKenzie (2009) highlighted that the diverse disciplinary interest in QoL yields little consensus due to different underlying theoretical approaches and the great variety of measures used. According to Gilhooly et al. (2005), far more has been written about the measurement than about the essence of the concept of QoL. Furthermore, Levasseur, St-Cyr Tribble and Desrosiers (2009) are of the opinion that QoL is difficult to estimate quantitatively because it has a deeply set subjective meaning as well as an intrinsic psychological dimension associated with the meaning of life and essence of the person.

Subjective and psychological well-being has begun to enjoy more attention in the study of QoL (Adelman, 1994; Fitzpatrick, 1999; Fry, 2000; Gabriel & Bowling, 2004). However, studies concerned with QoL within the specific discipline of psychology likewise tend to conform to numerous areas of focus. Baltes and Smith (2003) particularly argued that

many studies focus on a singular factor of QoL or on a specific domain, which has the effect that established psychological QoL models have rarely proven to be multi-level or multi-domain (Gabriel & Bowling, 2004). Already in 1974, Ziller made a distinction between overall QoL and subjective QoL. He argued that societies have common core values such as control, autonomy, pleasure and self-realisation that influence overall QoL and that subjective QoL is influenced by individual experiences. Despite this important insight, many psychological gerontologists have failed to define and measure QoL empirically by not including individual older people's subjective experiences of QoL and not taking other social circumstances into account (Gabriel & Bowling, 2004; Hyde, Wiggins, Higgs, & Blane, 2003).

A Psychological Perspective on QoL

Psychological perspectives on QoL shed light on the wellness in human beings. Paradigms of pathogenic, salutogenic and fortigenic thinking can furthermore be distinguished. Particularly psychology, as well as the other social sciences, has up to very recently operated mainly from a paradigm of pathogenic thinking (Linley & Joseph, 2004; Strümpher, 1990). Typical indices of psychological health and well-being still largely focus on illness, pathology, vulnerability and risks, indicative of the popularity of a pathogenic paradigm (Wissing, 2000). When QoL is studied and conceptualised in terms of a medical model only part of the picture with respect to QoL is represented. A salutogenic perspective has addressed the impeded view on people and aimed to be corrective by placing all individuals somewhere on a continuum of being well or unwell (Antonovsky, 1987). From this perspective the focus of any study moves away from constraining factors (pathology), to the person's current/specific position on the continuum. Antonovsky (1984) also stated that stressors are universal to all human beings, therefore a salutogenic paradigm holds that not all stressors are inherently bad but may also have salutary (enhancing) consequences.

Spreading from the salutogenic paradigm is the fortigenic paradigm, which draws attention to people's strengths, resources and capacities (Wissing, 2000). A fortigenic paradigm moves away from the pathology and deficits in humans and emphasises promoting their strengths and capacities. Such a shift in the conceptualisation of QoL is indicative of its origins in positive psychology (Linley & Joseph, 2004; Seligman & Csikszentmihalyi, 2000).

Positive psychology and QoL. Within the broader fortigenic paradigm, the sub-discipline of positive psychology is found (Seligman & Csikszentmihalyi, 2000; Strümpher, 1995). In its historical context, the epistemology of positive psychology has largely conformed to a more deductive and quantitative research approach (Linley, Joseph, Harrington, & Wood, 2006.). Sheldon and King (2001) argued that the focus of social research interest should be on understanding the entire breadth of human experience, from loss, suffering, illness, and distress through connection, fulfillment, health, and well-being. Their suggested approach has the potential to not only highlight pathology or dysfunction but also to add weight to the functionality of a system. An 'understanding' of human behaviour calls for an inductive inquiry (Ritchie & Lewis, 2003). Seemingly the discipline has made advances to adapt and suit the goal of qualitative research.

Positive psychology attempts to be an important corrective and calls on mainstream psychology to revive the positive aspects of human nature and positive individual traits and civic virtues (Seligman & Csikszentmihalyi, 2000). Dunn and Dougherty (2005) referred to positive psychology as the science of understanding human strengths to help people psychologically and physically. More recently, Linley and Joseph (2012) stated that positive psychology seeks to understand the factors that facilitate optimal functioning as much as those that prevent it.

This branch of psychology is mainly ordered around two approaches. The first is the hedonic approach that defines happiness and the good life in terms of pleasure seeking and pain avoidance. This study adhered to the second and eudemonic approach that defines happiness and the good life in terms of achieving one's full potential (Carr, 2004). According to Seligman (1998, 2002), human beings should be viewed as having inherent potential for developing positive character traits or virtues. The inherent potential of older persons lies at the core of the actualising tendency as described by Rogers (1959) and self-actualisation as described by Maslow (1954). Furthermore, Aldwin (1994) proposed that human beings are faced with ever-changing demands (such as ageing) with which they have to cope. According to his thinking older people may develop certain capacities and strengths in response to functional limitations and challenges experienced in old age. Such positive character traits and capacities would essentially also inform their QoL.

Study in the field of positive psychology at the subjective level concerns well-being, contentment, satisfaction, hope, optimism and happiness. At the individual level it concerns positive individual traits, the capacity for love, vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future mindedness, spirituality, high talent and wisdom. At the group level it concerns civic virtues and the institutions that move individuals toward better citizenship, responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic. The outcomes of positive psychology may be defined as the subjective social and cultural states that characterise a good life, a life of quality or quality of life (Linley et al., 2006).

Psychology of ageing and QoL. Ageing is considered to be a natural, universal complex and highly individual process characterised by progressive declines in the function of most physiological and psychological systems, which leads to increasing frailty (Skelton & Dinan-Young, 2008). A consensus definition of ageing is a process or group of processes

occurring in living organisms that begins with birth and with the passing of time leads to a loss of adaptability, functional impairment and eventually death (Spiriduso, Francis, & MacRae, 2005). There is often little consistency across studies on the question of when late life begins. Over several years one may observe a person's physical and mental characteristics change and it is difficult to pinpoint one precise moment in this process when a threshold was crossed (Belsky, 1999; Stuart- Hamilton, 2006).

A wide range of methods exist with which to describe the age of a person. The most common will be chronological age which is simply a measure of how old a person is. A common response amongst some researchers to the arbitrary nature of chronological age has been to emphasise functional age, which essentially means the average age at which a particular level of skill is found (Thane, 2000; Young, 1997). Young (1997) in particular reasoned that older people are far from being a homogeneous group as they are increasingly diverse in their medical, psychological and physical status. Further division into 'young old' and 'old old' has also been commended by some, and another method divides people over 65 years into a third and fourth age. The third age refers to an active independent lifestyle and fourth age to a final period of dependence on others (Stuart-Hamilton, 2006).

Various thresholds have been set by demographers of different countries; some see old age at 60 years, others at 65 years. Furthermore, geriatricians see their specialty as commencing at around 75 years (Skelton & Dinan-Young, 2008). Some agreement has at least been reached regarding the term 'elderly' as being unhelpful as it implies uniformity that belies the considerable differences that result from a broad age range and inter-individual differences in the rate of ageing (Cuthbert, Blakemore, & Jannett, 2001). Gerontologists tend to select a figure of 60 years or 65 years to denote the age of onset, as various psychological and physical changes tend to manifest around this threshold (Bromley, 1988; Decker, 1980). In this study, people of 60 years and over were considered as older people. Apart from

describing stages of ageing or onset of ageing, efforts to examine behaviour in old age are more recent when compared to examinations of behaviour in children as one of psychology's oldest fields of inquiry (Birren & Schroots, 2000). The psychology of ageing is the study of behaviour in the ageing phase of life (Belsky, 1999). Over the past few decades the psychology of ageing has become an established field and, as described by Belsky (1999), the field is bound to branch out to many other fields. The behaviour of older people is shaped by everything from their health status, cognitive capacity, their historical context and their socio-economic-position.

According to Gilleard and Higgs (2005) as well as Higgs et al. (2005), the QoL of people should at the very least be considered in terms of a cohort or generation. These terms (generation/cohort) have not been consistently defined in the literature (Bengtson, 1975). In this study the term 'generation' will be used to refer to a broad age group or cohort born during the same historical period, experiencing similar levels of life-cycle development. According to Blazevidiene and Jakusovaite (2007), a cohort or generational group constitutes those members who share historical or social life experiences. These so-called historical life experiences tend to distinguish one generation from another. In order to understand the diversity of individuals over time, Bengtson, Elder and Putney (2005) are of the opinion that they must be studied in a historical context. The members of each generational cohort hold certain common views and shared perspectives on life. An understanding of these generational differences is critical to policy makers, researchers, services providers or other role players who aim to advance the philosophy and knowledge surrounding a given phenomenon, in this case the QoL concerned with a specific generation (Liubiniene, 2003).

Theories in psychology of ageing. Theories concerned with the psychology of ageing can be described as systematic efforts that attempt to organise and explain behaviour within a coherent framework (Stuart-Hamilton, 2006). Belsky (1999) drew attention to a limitation in

the psychology of ageing. She stated that research and theory in this field of psychology are seldom steered by questions concerning the extent to which individuals are able to grow, since the main focus has been on age-related decline, loss and constraint (Cavanaugh & Blanchard-Fields, 2007). Psychological theories of ageing include lifespan development theory (Baltes & Smith, 1999), the theory of selective optimisation with compensation (Baltes & Baltes, 1990), socio-emotional selective theory (Carstensen, 1992), cognition and ageing theory (Salthouse, 1999), personality and ageing theory (Levinson, 1978) and gerotranscendence theory (Tornstam, 1996). Each of these theories has the capacity to contribute to the study in different ways, but the main focus was placed on lifespan development theory, which is the most recent and widely cited explanatory framework in the psychology of ageing (Johnson, 2005). Lifespan development theory favours the continuous developmental capacity of older people despite the limitations of ageing.

Lifespan development theory conceptualises ontogenetic development as biologically and socially constituted, revealing universal developmental traits (similar for all older people) as well as inter-individual variability (for example differences in social class, genetics and historical background) (Baltes & Smith, 1999). Three principles have been identified to regulate the dynamics between biology and culture (social aspects of a person) across the lifespan of a person (Baltes & Smith, 1999). Firstly, as age increases the selection benefits of individuals decreases. In lay terms this implies that older people have fewer options for big choices, meaning that smaller ones often increase in value (Ball et al., 2000). Secondly, people are more inclined to have a need for their own culture as they age, and thirdly the efficacy of culture decreases with age. Their focus is on how the adaptive fitness and resilience of older people are influenced by the dynamics of lifespan development. Baltes and Smith (1999) postulate that a condition of loss or constraint has the ability to catalyse positive change in older people. Lifespan development theory is furthermore aligned with the

researcher's ontological assumptions that social reality is not fixed (Giorgi & Giorgi, 2008) and that older people's physical, cultural, historical and environmental conditions have an impact on how they perceive QoL. This also complies with Bengtson, Elder and Putney (2005), who stated that contemporary perspectives of QoL in old age cannot be regarded as an absolute truth for all older people.

PROBLEM STATEMENT

In South Africa more research is called for to understand what builds towards or constructs the QoL of older people in the context of residential care facilities. The purpose of these facilities in South Africa differs quite extensively from international views of care institutions. In the American literature, care facilities refer to any personal care or assistance that an individual might receive on a long-term basis because of a disability or chronic illness that limits his or her ability to function (Kane & Kane, 2005; Joseph, 2006). In addition, long-term care may be provided in a range of settings such as an individual's home and residence, assisted living, nursing care, or rehabilitation facilities.

Long-term care facilities are frequently referred to as nursing homes and offer the solution of a last resort when the older individuals are no longer able to continue living at home in their community, or when the family and/ or care givers are no longer able to provide appropriate care when a person becomes too frail (Goodman & Redfern, 2006). According to Vetter (1999), there is a general resistance towards residential long-term care in the UK as older people prefer to receive support at their homes. Older people in other European countries such as France and the Netherlands have become less resistant to move to nursing homes as care at home is costly and a broader range of medical and social services are often available in these nursing homes (Reed, Roskell-Payton, & Bond, 1998).

In South Africa the term ‘residential care facilities’ has become an elegant substitute for ‘old age homes’. Unlike the American model, these care facilities are occupied primarily by older people, also not sporadically but often indefinitely. In most instances it is white older South Africans who reside in these facilities. Similar to trends in the UK, older people of other ethnic groups stay engaged in the community, often with family members. However, in South Africa this is often due to poverty and sub-standard socio-economic circumstances. The tendency for white older people to move to care facilities is becoming more prominent for various reasons including safety, the migration of children, a lack of filial piety, and reduced responsibilities such as that of maintaining property. This group of older people represents the largest and most rapidly growing ageing cohort in South Africa, despite the fact that they are fewer in numbers comparatively. Proportionally, this group of older people will largely increase in the next decade; meaning that more people will probably resort to these residential settings.

The residents of facilities are not all frail older people. In many instances the older people are still very functional and are not in need of acute care. The need for acute frail care is most prominent in the oldest of old residents as well as those with terminal illnesses, dementias or other neurodegenerative disorders. The situation in residential care facilities can be sketched against the backdrop of a large group of residents that are still active and functional and able to participate and engage socially.

Despite the legislation and the policy frameworks that have the objective to enhance the well-being and QoL of all older people in South Africa, various reports (Department of Social Development, 2006, 2007, 2008, 2010) give reason to believe that the QoL of the majority of older people within residential care facilities is far from being satisfactory. Van der Walt (2011) described the circumstances in residential care facilities in South Africa as

challenging for older individuals. She found their sense of community to be low and therefore a call was made for further psychological research as well as interventions.

Previous research concerned with the QoL of older people in the South African context is scant. Available resources have focused mainly on older people in rural communities or on older people who still live independently, with such inquiries deriving from economic or health- orientated perspectives (Ferreira, Lund, & Møller, 1995; Ferreira, Møller, Prinsloo, & Gillis, 1992). None of these studies yielded a psychological perspective and neither did they include the personalised accounts of older people regarding what they considered to be important in terms of their QoL.

PURPOSE OF THE STUDY

The purpose of this qualitative inquiry is to understand how older people construct their QoL in residential care facilities in South Africa. The primary research question that guided the study was:

- How do older people construct QoL in the environmental setting of a residential care facility?

Hyde et al. (2003) stated that many writers on QoL have confused *influences on QoL* with *QoL*, and therefore the following sub-questions were also asked:

- What is the nature of QoL according to the perceptions of older people in residential care facilities?
- What are the contributors and inhibitors of QoL for older people in residential care facilities?

The findings from these two questions will be used to develop a conceptual model to explain the QoL of older people in residential care facilities.

The significant contribution of this research aims to reveal a typology of how QoL can be understood for this particular group of older people in their context. An in-depth understanding of the strengths of older people as well as their capacity to adapt, might enable current resources to be put to better use. In discovering the potential of older individuals this could facilitate improved or optimal individual and collective functioning in care facilities.

ONTOLOGICAL AND EPISTEMOLOGICAL ASSUMPTIONS

The ontological assumption on which this research is based is that reality is formed out of multiple socially constructed realities and that there is no single shared social reality, only a series of alternative social constructions (Denzin & Lincoln, 2005). The researcher adopts a relativistic stance in terms of the way in which the older person relates to and interacts with their environment; this impacting on their QoL. This study will therefore explore the individual's experience and perceptions as well as the social environment (Maree, 2007). Therefore, the realities of the participants' perceived QoL can be expected to differ in other social contexts and the factors of QoL will also vary between the older people under investigation.

An epistemological position is concerned with ways of knowing and learning about the social world by means of theoretical paradigms and perspectives (Denzin & Lincoln, 2005). Interpretivism and social constructivism as epistemological stances, define the researcher's view of how knowledge about the world can be obtained. Interpretivism holds that the researcher and social world impact each other, facts and values are not distinct and the researcher can declare and be transparent about her assumptions (Lincoln & Guba, 2000).

Dynamic interaction between the researcher and the participant is perceived as central to capturing and describing the lived experience of the participant (Lincoln & Guba, 2000). This paradigm is furthermore sensitive to the role of contextual factors which might influence QoL and to the researcher's instrumental role in the process.

Social constructivism holds that social phenomena are negotiated socially and historically (Maree, 2007). In other words, QoL is not simply imprinted on older people but is formed through interaction with others and through historical and cultural norms (across the lifespan). The socio-political culture in which the participants were socialised was taken into consideration. Consequently, the meaning of QoL can be varied and multiple as well as inwardly and outwardly directed. Such a paradigm enabled the researcher to investigate a complexity of views rather than narrow the meaning into a few categories or ideas by relying as much as possible on the participants' view of the situation (Snape & Spencer, 2003). The analytical frameworks as well as the presentation of results adhered to the criteria of credibility, dependability, transferability and conformability as proposed in a social constructivist paradigm (Denzin & Lincoln, 2005).

DESIGN AND METHODOLOGY

The research was conducted as an inductive exploration of the QoL of older people in the specific social environment of residential care facilities in South Africa. The research was non-empirical in nature and lent itself towards conceptual analysis as well as theory-building design strategies (Mouton, 2009). Three subsequent areas were explored: personalised perspectives and descriptions regarding the nature of QoL; contributors and inhibitors of QoL; and a conceptual model for the participants of the study.

Qualitative research was the emergent methodological approach for this inquiry. Holloway and Trodes (2007) have suggested that the researcher conducting qualitative research should articulate explicitly, at the beginning of the study, the kinds of knowledge the specific study might generate. Hence, this study aimed to generate propositional information that could stimulate, add to and elaborate existing academic knowledge concerned with QoL of older South Africans. An additional aim was to supply the end-users in residential care facilities with a usable account of the research findings.

The richness and depth of explorations and descriptions that a qualitative approach yields is regarded as one of its greatest strengths (Maree, 2007). An emphasis on meaning has constituted an overarching focus of this qualitative interpretative study. Flick (2004) advocated the use of qualitative methods to study social and psychological processes, as it takes into account micro-perspectives in order to analyse phenomena on micro-, meso- and macro-levels.

Phenomenology emerged as an appropriate research design in this qualitative exploratory study (Giorgi, 1997; Ritchie, 2009). A phenomenological study describes the meaning that several individuals ascribe to their lived experiences of a concept or phenomenon such as QoL. The phenomenological researcher focuses on describing what all participants have in common as they experience a phenomenon; this phenomenon being the participants' experiences of QoL. The basic purpose is to reduce individual experiences with a phenomenon to a description of universal essence (Creswell, 2007). Giorgi and Giorgi (2008) outlined the major procedural steps toward employing psychological phenomenology as follows:

- Determine whether phenomenology is the best theoretical approach to study the phenomenon at hand. It is suitable if this approach brings the researcher closer to

understanding the common experience of several individuals of a phenomenon. It is important to understand the common experiences in order to develop practices or policies or to develop a deeper understanding about the features of a phenomenon.

- State why it is interesting to study a specific phenomenon.
- Realise and specify the philosophical assumptions by taking note of objective reality and individual experiences.
- Data are collected from individuals who have experienced the phenomenon.
- Multiple data-collection techniques are accepted.
- The analysis moves from horizontalisation to a cluster of meanings.
- The researcher should be able to reflect on own experiences.
- From structural and textural descriptions the researcher then writes a composite description that presents the essence of the phenomenon, called the essential invariant structure.

Upon careful consideration and scrutiny of the research question and adherence to the above-mentioned recommendations by Giorgi and Giorgi (2008), phenomenology was ascertained to be an appropriate research design for this study.

Research Context

The transition from independent living to living in an institution has been described as challenging for older people, as various intrapersonal and interpersonal sacrifices are required in order to adapt in a new setting (Lee, Woo, & MacKenzie, 2002). Privacy is often compromised and physical living space is drastically reduced. Depending on individual circumstances, institutionalised living can be either fostering or very frustrating to the older individual and has a prolific impact on the way they experience QoL. The research occurred in the context of four residential care facilities in South Africa. According to the Older

Persons Act, Act 13 of 2006, (Department of Social Development, 2006), a residential care facility is defined as “a building or other structure used primarily for the purposes of providing accommodation and of providing 24-hour care to older persons”. Many such facilities are registered as non-profit organisations that receive support from the government in the form of subsidies. These subsidies are often not sufficient to sustain the residential care facilities, and, consequently, pensions of the residents are used to supplement the cost of the facilities (Van der Walt, 2011). Other facilities are run independently like a business, registered as non-government organisations. At independent facilities residents usually buy a small apartment on the premises, acquire life rights or rent their accommodation on a long-term basis. The residents themselves or their families pay for the services provided by these facilities.

The Older Persons Act, Act 13 of 2006 (Department of Social Development, 2006) furthermore makes provision for three categories of residential facilities, namely Category A (independent living), Category B (assisted living) and Category C (frail care). It is important to note that some facilities constitute all three categories on one premises, whereas others provide only one living arrangement. The four facilities that formed the research context for this inquiry each comprised all three categories. Two of the facilities were situated in an urban area in the North-West province and the other two in an urban area in the Free State province. The following services were offered by all four facilities: nursing, frail care, assistance with activities of daily living, laundry services, housekeeping services, prepared meals, a salon as well as a doctor who visited the facility once a week. Many residents still function independently, while the frail residents rely solely on the services provided. Care givers form an integral part of the functionality of such a facility, with nursing staff working very closely and directly with those older individuals in need of assistance. The facilities in

this inquiry had an appointed person, either a nurse or someone with a background in social work who focused on the social needs of the older people.

Two of the facilities were more advanced in terms of the activities that it provided for older people as a means to keep them socially engaged, although organised activities such as reading groups, bible study groups or walking groups were commonly found in all facilities. The infrastructure of the facilities may be graded as average to good when compared with other care facilities offering the same living arrangements and care plans. The researcher opted for facilities with an average status to avoid obtaining biased perspectives from older people residing in either limiting or lavish residential environments.

Participants

Residential care facilities are a popular choice for older people for various reasons including safety, security, financial sustainability, care, comfort, service, socialisation and a lack of filial piety (Wanless, 2001). Reference is once again made to the tendency of largely white older people to opt for institutional living - for many older people this is their only option. Afrikaans-speaking, white older South Africans participated in the research. Older people of other race groups did not reside in the residential care facilities that formed part of this research. Willing participants of both genders above the age of 60 years and who were able to communicate congruently and understood the purpose of the research participated in various rounds of data collection. Altogether 54 (male, n=10 ; female, n=44) older people, with ages ranging between 62 years and 95 years participated in this study. The researcher aimed to establish better homogeneity by having various small groups of older people in similar residential settings participate (Mouton, 2009) and explore constructions of QoL across various contexts.

Data Collection

Data were gathered through various rounds of enquiry by the researcher and three intern Masters students in Psychology. Individual in-depth interviews (Denzin & Lincoln, 2005) of an average duration of 60-90 minutes were conducted with participants (n=8). Four focus group investigations (Curtis & Redmond, 2007) consisting of an older group (>75 years, n= 5), younger group (<75 years, n=5) and two mixed age groups (n=6 and n=8) were conducted. Nine participants reflected on QoL in journals (n=9) (Alaszewski, 2006). Participants also constructed their perceptions of QoL in visual representations by means of the Mmogo-method® (< 75 years, n=8 and > 75 years, n=5) (Roos, 2008). A concluding round of data collection in terms of thematic validation was conducted towards the end of this inquiry by conducting Interactional Qualitative Analysis for analytic purposes, with 19 willing older participants who also participated in preceding rounds of data collection (Northcutt & McCoy, 2004). Please see Figure 2 for an outline of the data collection procedures.

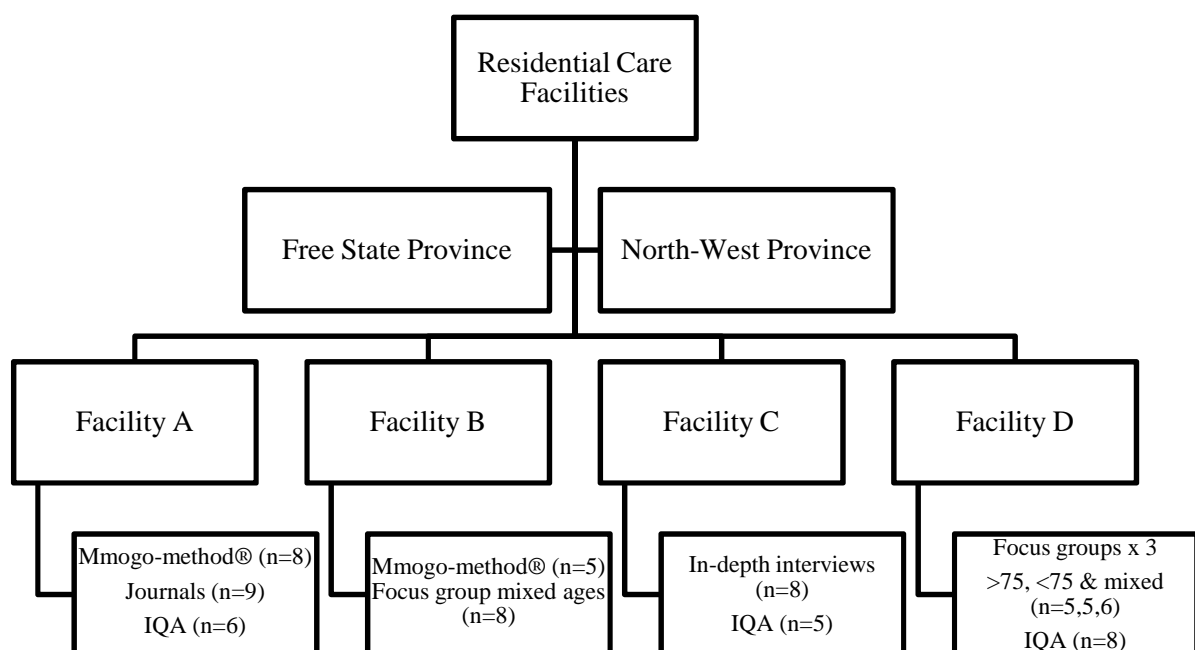


Figure 2. Layout of data-collection procedures

The three sub-studies that flowed from this qualitative inquiry (Articles 1, 2 and 3 of this manuscript) drew their data from the global pool of qualitative information obtained from the participants in the different settings. The specific data-collection techniques that applied to each study and the number of participants that formed part of each sub-study will be discussed in depth in the subsequent articles.

Procedure

The first step in the research process was to obtain permission from the managers of the facilities where data were collected. Initial contact with the participants was made by means of a facilitation session which was scheduled in advance. All residents of the facility were cordially invited to attend this session. The researcher and the Masters students in Psychology who assisted with data collection explained the purpose of the research and the scope of involvement for participants. Each step of the research process as well as the various data-collection techniques were explained at this session. The residents who decided to be part of the facilitation session had the choice to either identify themselves as participants or to withdraw from any further involvement. The data were gathered at the various care facilities towards the end of 2010 and the beginning of 2011. A final round of data collection took place in 2012, where participants had the opportunity to validate research findings by means of Interactive Qualitative Analysis. Towards the end of this study the researcher compiled a concise report containing results and information relevant to the facilities. The report also included the conceptual model of QoL and some recommendations based on the findings of this study. Each of the facilities received a copy. Please see Appendix E for a copy of this document.

Data Analysis

Analysis of textual data. An interpretative phenomenological analysis was conducted on all textual data since such analysis works well with texts generated by participants (Smith, Flowers, & Larkin, 2009). Meaning is central in interpretative phenomenological analysis as the aim is to understand the content and the complexity of meanings rather than measure frequency (Reason, 2003). The following served as a basis for analysis:

- Line-by-line analysis of the concerns and understanding of the participants.
- The identification of the emergent patterns.
- The development of a 'dialogue' between the researcher, the coded data, and psychological knowledge.
- The development of a structure, frame or *Gestalt* that illustrates the relationship between the themes.
- Organisation of the material in a format that allows tracing of the analysed data through the process.
- The use of supervision or audit to help test and develop the coherence and plausibility of the interpretation.
- Reflection on the researcher's own perceptions, conception and processes.

Analysis of visual data. Data collected by means of Mmogo-method® were analysed by means of visual analysis and complied with the suggestions of Roos (2008). The analysis incorporated the following four steps:

- Step 1: Asking the participants about each object that was made to determine the literal meaning of the object;
- Step 2: Determining the relationships between the different objects in the visual representations;

- Step 3: Applying the visual representations to the research question in order to provide insight into the migration experiences of the participants; and
- Step 4: Exploring the cultural meanings manifested in the symbolic use of objects.

According to Roos (2008), visual representations reflect the conscious meaning that participants project about a particular phenomenon related to the research question.

Interactive Qualitative Analysis. There are subject areas in which the phenomena to be studied will be deeply set within the participants' personal knowledge or understanding of themselves and perhaps related to the origins of longstanding values or beliefs (Snape & Spencer, 2003). IQA aims to provide a systematic and liable framework for qualitative inquiry. Northcutt and McCoy (2004) maintain that IQA is a suitable design for analysis when examining phenomena which are socially constructed. IQA directly opposes the idea of the researcher being the sole interpreter of data. Participants are granted the opportunity to interpret their own data. Main themes were presented to individuals in a group setting. Nineteen (19) older people who also participated in the initial stages of data collection formed part of the IQA process. The themes were presented to them visually on a flipchart as well as being documented on an individual handout. The participants reviewed the themes, expressed the connections and/or relations among themes and were given the opportunity to share additional thoughts concerned with the subject matter that might have originated since the first wave of data collection. IQA as a methodology is discussed in greater detail in Chapter 4.

RIGOUR OF THE STUDY

In qualitative studies, trustworthiness entails solidity, consistency and validity (Creswell, 2003). Trustworthiness refers to a researcher's ability and reputation to conduct a study legitimately. Trustworthiness as a means of ensuring credibility has been highly

disputed in recent years and therefore key markers for quality in qualitative studies were employed to enhance the rigour and trustworthiness of the study. The criteria for quality as described by Tracy (2010) are discussed in general in Table 1 and will be elaborated on when applied to particular articles of this manuscript.

Table 1.

Criteria for quality in qualitative studies

Criteria for quality	Description of criteria
Worthy topic	Worthy topics emerge from disciplinary priorities, are timely societal or personal events, have educative authenticity and point out new knowledge.
Rich rigour	High-quality qualitative research is marked by a rich complexity of abundance in contrast to quantitative research that is more likely appreciated for its precision. Descriptions are rich and bountifully supplied.
Sincerity	Sincerity as an end goal relates to notions of authenticity and genuineness. The research should be marked by honesty and transparency.
Credibility	Credibility refers to the trustworthiness and plausibility of the research findings.
Resonance	Resonance refers to the ability of the research to meaningfully reverberate and affect an audience.
Significant contribution	When judging the significance of a study's contribution, researchers gauge the current climate of knowledge, practice and politics.
Ethical	Please see the section below which is dedicated to the ethical considerations of this study.

The rigour of the study was further enhanced through crystallisation. Crystallisation gives depth to research through the application of a variety of data collection- and analytic methods (Ellingson, 2009). In addition, member-checking by means of Interactive Qualitative Analysis (IQA) was also employed (Northcutt & McCoy, 2004).

ETHICAL CONSIDERATIONS

Ethical approval to conduct the research was obtained from the North-West University's Ethics Committee. This research obtained ethical permission under the title of the broad research project, namely: *Exploring enabling contexts* (with the number O5K14). Permission was also obtained from the managers of all four facilities to conduct the research on their premises. Prior to engaging in data collection all participants were clearly informed of the voluntary nature of their participation and of the goals and objectives of the research. The participants were informed of the time required for each of the various data-collection activities. They were reassured that they could withdraw from the study at any time and were not obliged to give an account of life experiences that they did not feel comfortable sharing. Counselling was offered in the event of emotional disparity subsequent to participation. The privacy, anonymity and confidentiality of all information obtained from the participants were assured.

The participants gave written informed consent and afforded the researcher the right to use results of this research for publication purposes in scientific journals as well as conference presentations. The data are in the safe-keeping of the researcher.

The personal orientation of the researcher was to establish good rapport with the participants and value their individualism. Egan (1998) gave a description of norms that translate the value of respect into interpersonal interaction, namely caring about the welfare of the individuals (in this case, the participants) and doing no harm.

REFLEXIVITY OF THE RESEARCHER

In this section I would like to draw attention to my personal reflexivity as I have already expressed both my ontological and epistemological views in a preceding section of this manuscript. As a part of my reflective process as a qualitative researcher, as described by Willig (2008), I continuously examined my own perceptions of the QoL of older people in residential care facilities. I was aware of the age difference between the participants and myself – I am nested in a much earlier life stage in terms of development compared to the life stage of the participants. This could easily have led to a biased opinion of the participants' experiences. Key aspects of conducting myself as an ethical researcher included being genuine, empathic and respectful of the participants. I endeavoured to take seriously the role of the older people as social actors negotiating their own social world (Giorgi, 1997).

I tried to be sensitive and observant of body language and kinetics. Having spent prolonged periods of time at residential care facilities as a researcher and volunteer, I became aware that older people can be very apprehensive, especially in a research context. Whenever I came under the impression that a participant was reluctant to share experiences because of mistrusting the intention of the research, I tried to reestablish rapport by calmly addressing the mistrust. I furthermore explained that personal perspectives regarding QoL were needed to learn about the construct. Participants always complied when they felt like they were making a contribution and their opinion was deemed crucial to this inquiry. Many of the older people were eager to raise their opinions about their current circumstances. I experienced the participants as willing to participate and this was apparent from what they said verbally and revealed through their body language. It was only in collecting data by means of the Mmogo-method[®] that two male participants were not keen to visually construct their experiences although they were open to conversations regarding their QoL at the facility. These discussions were included as part of my field notes. I ascribed their actions to group

dynamics and suspect that they did not want to lose face by discussing their personal experiences in front of the other group members.

I devoted myself to providing a true and accurate account and reflection of the data, despite my own opinions. Furthermore I have tried to be as transparent, informative and factual as possible with regards to how this qualitative study took place and thus have provided the reader with the various appendices and an accompanying CD. These documents and the CD include the more technical aspects of this research and the processes that took place behind the scenes. I also shed light on the limitations and challenges of this study in Chapter 5.

To say that I learned a lot from this academic pursuit would be an enormous understatement. The study developed me on various levels apart from adding to my academic and professional development. The process forced me to think critically about issues that are very real in the social world but also very close to my heart. I learned a whole lot about South African history, valuable information that I might otherwise have missed. I now view my own position as one of being able to accumulate knowledge (by doing research) and actually learning from it personally. I became thoroughly aware of the utmost importance of good, qualitative relationships throughout life. I feel privileged to have had the opportunity to sit at the feet of those who know and have experienced so much more than I have. The people³ with whom my path crossed along the way in itself compensated for the many times I felt confused, tired and worried about the study towards the end of this journey.

³People who contributed to my journey: Drs Northcutt, McCoy, Walker and the late Dr Oberholzer; Messrs. van der Poel, de Klerk, and Xiao; Ms. Diener, O'Neal, Kaiser, Alder, Banister, Botha, Naidoo, Loots, and Jackson.

STRUCTURE OF THE RESEARCH

This study is based on the analysed results of both textual and visual data. The researcher used a variety of data-collection techniques to capture rich data in order to answer the various research questions as stipulated under the purpose of the study. By means of these three articles the researcher aimed to give a structured account of the results. The conclusions and recommendations are based on the findings of all three articles. The figure below illustrates the structure of the study:

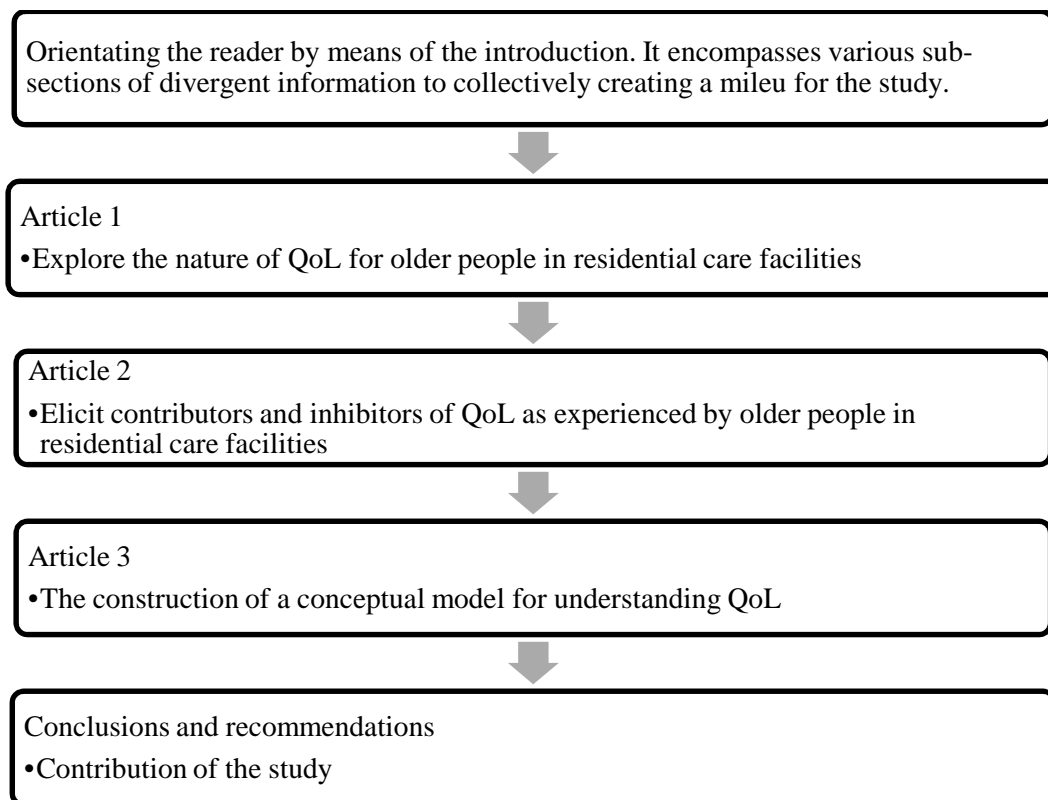


Figure 3. Structure of the study

LAYOUT OF THE RESEARCH REPORT

Chapter 1

Introduction: Context, Conceptual Framework and Research design

Chapter 2

Article 1: The Nature of Quality of Life for Older South African People in Residential Care Facilities

Chapter 3

Article 2: Contributors to and Inhibitors of Quality of Life for Older People in Residential Care Facilities in South Africa

Chapter 4

Article 3: A Conceptual Model of Quality of Life for Older People in Residential Care Facilities in South Africa

Chapter 5

Conclusions and Recommendations

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CHAPTER 2

ARTICLE 1

THE NATURE OF QUALITY OF LIFE FOR OLDER SOUTH AFRICAN PEOPLE IN RESIDENTIAL CARE FACILITIES

The Nature of Quality of Life for Older South African People in Residential Care Facilities

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Abstract

This study aimed to describe the nature of quality of life (QoL) from the perspective of older South Africans in residential care facilities. Forty-one (41) willing participants of both genders (male, n=10 ; female, n=31) who were able to communicate congruently (ages ranged between 62-95 years) participated in individual in-depth interviews and focus groups. Participants also made narrative reflections regarding their QoL in journals. Data were analysed by means of interpretative phenomenological analysis. Participants' views complied with the findings of other researchers that have previously described QoL as a multi-dimensional phenomenon. The study contributed by providing a more nuanced description of particular domains that informed the nature of the QoL of the participant in this study. Specific reference is made to the role of spirituality in QoL, QoL in interpersonal contexts, self-regulation and the transitional nature of QoL. The study concludes with recommendations on how future studies can explore the QoL of older people in residential care facilities.

Keywords: Quality of Life; residential care facilities; older South African people; lifespan; qualitative inquiry

Introduction

Quality of life (QoL) research reflects a diversity of disciplinary interests, ranging from philosophy and medicine through to a variety of social sciences (Hambleton, Keeling, & McKenzie, 2009). According to Farquhar (1995) a profusion of published papers have dealt with the term 'quality of life', but in a heterogeneous manner, making comparison difficult. Furthermore, little consensus and noticeable contrasts exist between positivist and realist research approaches in QoL studies (Victor, Scambler, & Bowling, 2000). QoL and its properties have also been widely researched within a gerontological framework (Johnson, 2005; Redfern & Ross, 2006; Veenhoven, 2000; Walker, 2005). According to Daatland (2005), QoL is more than merely the subjective well-being of older people and it needs to be specified in order to be researchable as it covers multi-dimensional ground. There seems to be some sort of consensus around the issue of QoL being something distinct from happiness and psychological well-being (Ryff & Keyes, 1995; Wissing, 2000). A limited number of studies were found in the literature that focussed on older people's personal experiences of QoL in various social contexts and cultures (Bowling, 2001; Bowling & Gabriel, 2004; Cummins, 1997).

In the social sciences, QoL as a construct has been described as a jungle by Hambleton et al. (2009) as it is often used as an encompassing term to describe a vast range of life indicators of social phenomena such as health status, capacity to carry out activities of daily living, work-role status, availability of opportunities to pursue recreational interests, social functioning in relationships and friendships, access to nature and health care resources, standard of living and general well-being. The largest amount of work undertaken to investigate the experience of QoL in the older person has been empirical and quantitative in nature, through counting and classifying older people's circumstances (Bowling, Bannister, Sutton, Evans, & Windsor, 2002; Victor, 2005). The multitude of empirical studies on QoL

has led to the notion that no consensus has been established concerning the true nature of QoL as it pertains to a specific group of people. This can furthermore be ascribed to the immense variety of underlying theoretical approaches, the multitude of overlapping domains and the amount of diverse measures used to resolve the ambiguity of the construct (Farquhar, 1995; Hambleton et al., 2009; Kelly-Gillespie, 2009; McKee, Houston, & Barnes, 2002). According to Bowling et al. (2003), an additional cause for confusion is that QoL is often described by experts rather than by obtaining the subjective experiences of people. There has been increasing recognition that the evaluation of QoL is largely dependent on the person who experiences it (Bowling, 1995; Higgs et al., 2005).

As early as 1980, George and Bearon proposed that the QoL of older people includes a broad range of discrete domains and indicated that overlapping and diversified use of these domains are common. Hughes (1990) distinguished nine domains, namely cultural factors, health status characteristics, physical environment, social environment, socio-economic factors, personality factors, personal autonomy factors and subjective well-being. Kane (2001) distinguished as many as 14 domains: comfort, security, relationships, enjoyment, meaningful activity, functional capacity, autonomy, dignity, privacy, individuality, spiritual well-being, sense of purpose, satisfaction with life and financial well-being. Cummins (1996), who reviewed various definitions of QoL, identified emotional well-being, health, intimacy, material well-being, productivity, safety and community as prominent domains. Farquhar (1995) referred only to three broad domains with various sub-domains, which were labeled as social interaction, health and material well-being. George and Bearon (1980) regarded this inconsistent variety of domains as problematic and called for greater transparency about the research context, since particular domains are largely a matter of personal or group preferences, as different people value different things as important. The

complexity of QoL is also noted in the lack of a single definition of QoL and any given definition serves only as a guideline (Gilhooly, Gilhooly, & Bowling, 2005). The definition of Quality of Life (QoL) suggested by the World Health Organization will be used for this study: QoL is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHOQOL, 1993). From this definition it may be seen that QoL is very much individually informed.

Within the discipline of psychology, QoL can be explained from the theory of positive psychology which is the scientific study of ordinary human strengths and virtues working towards the good life (Seligman, 2002). The aim of positive psychology is to bring about a change in the focus of psychology from preoccupation with only the unpleasant and negative things in life to also building positive qualities (Seligman & Csikszentmihalyi, 2000). Positive psychology is ordered around two approaches, namely the hedonic approach that defines happiness and the good life in terms of pleasure seeking and pain avoidance (King, Eells, & Burton, 2004). This study adhered to the second and eudemonic approach that defines happiness and the good life in terms of achieving one's full potential (Carr, 2004). According to Sheldon and King (2001), positive psychology is interested in finding out what is functional and what can improve an average person.

This study sets out to study the QoL of an expanding older population in South Africa, in the social context of a residential care facility, by employing a qualitative approach to research. Qualitative research has the potential to contribute towards a better understanding of QoL in the later years since it is concerned with the meanings, values and experiences of older people. Current increases in the number of older people globally, and in South Africa, necessitate research concerned with their QoL as well as the nature thereof as it applies to specific groups and contexts. The way in which individuals construct QoL at various stages

of development and especially in old age, also remains a neglected but increasingly important area for research (Baltes & Smith, 2003). The current population figures of South Africa indicate that the country has a growing young black population and an ageing and shrinking white population (Stats SA, 2011). According to the 2011 national census, the South African population increased from 40.5 million in 1996 to 51.7 million in 2011 (of whom 41 million are black, 4.6 million are coloured, 4.6 million are white and 1.5 million are Asian/Indian). However, the number of white South Africans as a subpopulation has decreased (from 10% of the total population to 8.9%) due to low fertility and emigration despite the high mortality rates of this group. White South Africans represent 90% of all older people in residential care facilities in South Africa seeing that they are socially inclined towards institutionalisation.

Older people of other race groups in South Africa have an aversion to reside and be cared for in facilities that are predominantly occupied by white older people (Department of Social Development, 2010). A visible discrepancy in service provision, access to health care and socio-economic status of the various ethnic groups of South Africa was evident for many years prior to- and during the apartheid era (Westaway, Olorunju, & Rai, 2007). In particular, access to residential care facilities was permitted exclusively to white older people, this changing in 1994 with the transformation act making access to facilities possible for all race groups. Nonetheless, older people of other racial groups are more inclined and culturally accustomed to remain part of their communities or to reside with children or extended family members. White South Africans seem to have a culture of independence and it is not customary for them to reside with their children or families in old age. As a result, many older people have to be cared for in residential care facilities owing to their deteriorating health, loose social/cultural ties, the emigration of children and grandchildren, and their limited financial resources in their later years (Joubert & Bradshaw, 2006).

Older people who reside in residential care facilities are more likely to experience reduced QoL, according to Kane and Kane (2001). These authors found that decreasing physical abilities, changes in the living environment, rigid daily routines and altered social interactional patterns exercise a negative impact on QoL. In spite of the presumable decrease in overall QoL, a good physical environment and the availability of formal (health) care in care facilities are found to be significant predictors of mortality, physical dependence and service utilisation among older people (Dorr et al., 2006). However, their increased quantity of years has not been guaranteed to be accompanied by increased QoL. Baltes and Smith (2003) queried the value of continuing investments into extending the lifespan, as these investments may in fact, actively reduce the opportunities of an increasing number of people to live and die in dignity. Spirduso, Francis and MacRae (2005) are of the same opinion by stating that merely extending life years is of no value unless QoL can be maintained for the individual concerned. Limited international and local resources were found that employed a more person-oriented and qualitative approach in studying the multi-dimensional nature of QoL in the contexts of residential care facilities (Clark & Bowling, 1989; Farquhar, 1995; Fry, 2000).

Aim of the Study

This study aimed to achieve a better understanding of context-specific QoL. Greater knowledge of the fundamental nature of QoL is needed from the perspectives of older people. The following broad question therefore guided the study: What is the nature of QoL according to the perceptions of older people in residential care facilities? It is hoped that the findings of this study will contribute to a more nuanced understanding of aspects which inform the QoL of people against the backdrop of specific life-stage transactions and contextual influences.

Research Method and Design

Qualitative methodology was relied upon for this study. According to Ritchie (2009) the fundamental purpose of qualitative research is to explore and describe participants' understanding and interpretation of social phenomena in a way that captures the inherent nature thereof. Experts have suggested that more qualitative studies will deepen rather than quantify the nature of QoL (Daatland, 2005; Walker, 2005). Qualitative research enables the researcher to study what lies behind (in this instance - QoL), what underpins an attitude, way of thinking or behaviour (Creswell, 2003; Denzin & Lincoln, 2005; Smith, 2003). Qualitative studies create a platform from which categories can be distinguished as they emerge from the data (Terre Blanche, Durheim, & Painter, 2006).

Research Design

A phenomenological design in qualitative research is primarily concerned with describing everyday lived experiences precisely in the manner that it presents itself without taking into account or offering causal explanations (Giorgi & Giorgi, 2008; Giorgi, 1997). Phenomenology is based on the philosophical approach that studies experiences, more specifically experiences that constitute the lived world of human beings (Smith, Flowers, & Larkin, 2009). Phenomenology postulates that human beings are inextricably connected in their relationship with the world and with other human beings. The basic purpose of the chosen design is to reduce individual experiences of a phenomenon to a description of universal essence (Giorgi & Giorgi, 2008).

Research Context

Three categories of residential care facilities exist according to the Older Persons Act of South Africa, Act 13 of 2006 (Department of Social Development, 2006), namely:

Category A (independent living), Category B (assisted living) and Category C (frail care). A combination of these categories was relevant to this inquiry. The South African government subsidises some facilities to provide for the basic housing, healthcare and nutritional needs of older people (Van der Walt, 2011). The majority of well-functioning facilities are run independently, as a business or non-government organisation where residents either buy life rights on the premises or rent the accommodation and pay for services. Four independent residential care facilities situated in urban areas in two provinces of South Africa formed the basis for participant recruitment and data collection. These facilities were similar in terms of care provisioning and living conditions, although the availability of organised activities in which older people were able to participate varied among the facilities. With regards to the infrastructure of the facilities, participant in this study either resided in small apartments on the premises or in ensuite bedrooms. Residents shared communal areas such as the lounge, dining hall and the gardens. Most of the participants resided in one-bedroom apartments or ensuite bedrooms. The motivation for more than one site was to obtain data from participants who resided in multiple contexts with relatively similar circumstances in order to avoid biased perceptions of QoL (for example which could arise through a negative climate in a particular setting or through provoked group dynamics) (Mouton, 2009).

Participants

Afrikaans-speaking, white older South Africans residing in residential care facilities participated in the research. Older people of this racial group prefer institutional living and for many older people this is their only option. Older people of other race groups did not reside in the residential care facilities that formed part of this research. In this study 41 older people (female, n=31; male, n=10) with ages ranging between 62 and 95, who were able to express themselves coherently and understood the purpose of the research, participated. None of the participants were frail. It could be said that they had moderate socio-economic

circumstances. Bengtson, Elder and Putney (2005) place emphasis on the fundamental importance of historical conditions for understanding individual development in their context. The participants grew up in a society and era known for being conservative, religious and submitted to a strong patriarchal system that was evident in political and social orders (Codrington & Grant-Marshall, 2005). The historical and current position of many older white South Africans affords them good living conditions compared to the other ethnic groups. According to Staehelin (2005), with good living conditions comes increased life expectancy, and with this expected longevity comes the notion that older people can easily spend numerous years of their retired lives in residential care facilities.

Procedure

Permission to proceed with the research activities was obtained from the managers of the care facilities. An initial meeting was scheduled at the various facilities which invited all interested residents to an introductory discussion concerned with QoL. At this meeting the nature of the research was verbally communicated to the residents and the various data collection techniques were explained. Every individual also received a document which contained relevant information on the purpose and procedures of the study. Willing residents were then asked to identify themselves as participants, after which they had to give written informed consent to freely participate in the research.

Data were collected by the first author and three intern Masters students in Psychology. Appointments for interviews and focus groups were scheduled with the participants at convenient times. The first author and Masters students coordinated all appointments with the managers at each facility. These appointments were usually scheduled during mornings, when the older people still had sufficient energy and also not to hinder them from their afternoon rest. Morning appointments also provided the first author and Masters

students with the opportunity to enjoy tea with the participants. Journals were distributed among willing older persons at the initial meeting and were collected after 2 weeks.

Data Collection

Data obtained from qualitative research methods aims to explore the ways in which people construct social reality and the inherent meanings attached to these realities (Henning, Van Rensburg, & Smit, 2005). Multiple methods of data collection were utilised to gather information. Please consider Figure 1 for the layout of the data-collection procedures:

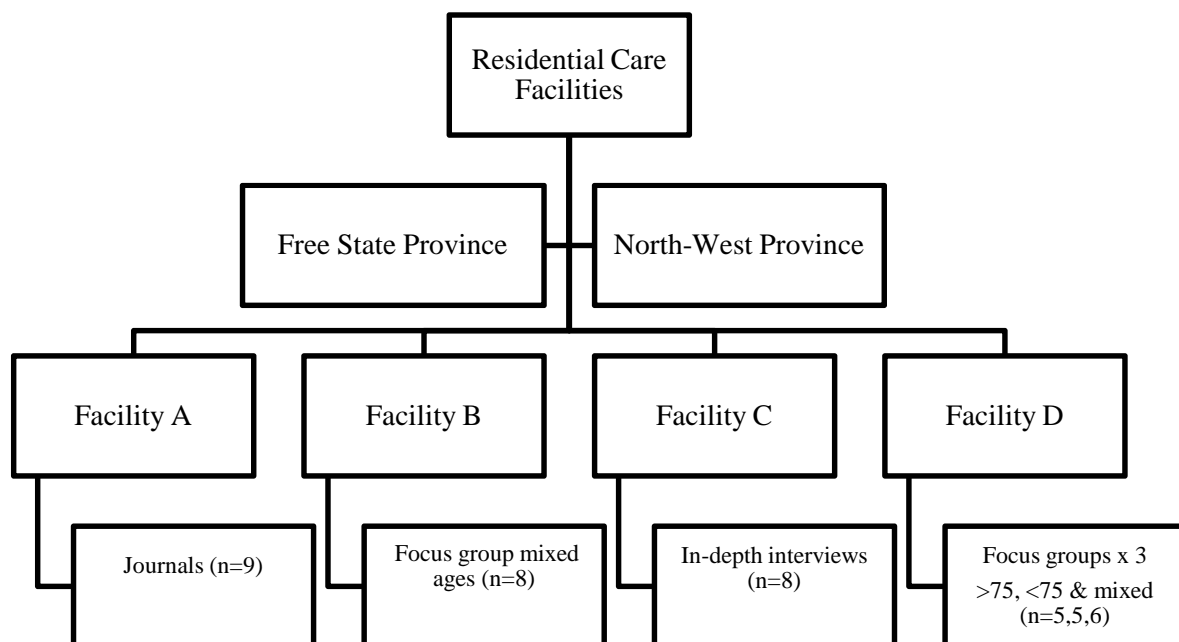


Figure 1. Layout of data-collection procedures

The study drew data from the collective pool of qualitative information obtained from the participants in the different settings. The specific data collection techniques will be discussed concisely.

In-depth interviews. In-depth interviews were used to obtain the participants' perceptions and to gain insight into the nature of QoL as they see and experience it (Creswell,

2003). Individual in-depth interviews were conducted with eight participants (n=8). The questions posed to participants in this study included: *Please share your perceptions on the nature of QoL; How would you define QoL?; How did you formerly view and experience QoL?; and How do you experience it now?* These questions correspond with the work of Farquhar (1995) who conducted a similar qualitative study among older people in England (UK). The duration of the interviews varied between participants. Interviews varied from 30-90 minutes. All interviews were conducted in the mother tongue of the participants and transcribed. The interviews were then translated into English.

Focus groups. According to Curtis and Redmond (2007), focus groups are especially useful when knowledge about the research question is inadequate and elaboration is required. The utilisation of focus groups was motivated by the thin descriptions of QoL that emerged from the interviews. The interview participants were eager to engage in lengthy conversations about their lives and circumstances but these conversations did not produce sufficient descriptions to shed light on the nature of QoL. The aim of the focus group in this study was to encourage self-disclosure and to capture how participants responded in a situation where they were exposed to the views of other older people regarding QoL in the same context, which provided a wider community view of QoL. Four focus groups consisting of an older group (>75 years, n= 5), a younger group (<75 years, n=5) and two mixed age groups (n=6; n=8) were conducted. Age-specific groups were conducted to control for ageing effects. Altogether 24 older people formed part of the focus groups. The same questions that were posed in the individual interviews were explored in the focus groups as well as new topics that came to the fore. The focus group conducted with the younger group was 45 minutes in duration, whereas the older group members shared their ideas in half an hour's time. The mixed groups gave their opinions in 49 minutes (n=6) and 33 minutes (n=8) respectively.

Journals. By means of journal inscriptions and narrative storytelling, participants gave voice to their experiences and opinions of QoL. According to Alaszewski (2006), the aim of journals in social research is for participants to narrate their thoughts about a certain phenomenon and to have the opportunity to return to the written text and supplement it with additional thoughts or information. This method is ideal in situations where individuals prefer to express themselves in writing compared to face-to-face conversations. The instructions for journal use and specific open-ended questions were pre-printed in the journals and were collected after two weeks. Questions included: *Please define QoL in your own words*; *What are the things that currently provide you with QoL?*; *What are the things that previously gave you QoL?*; and *Please feel welcome to share any additional thoughts on QoL*. Nine participants reflected and narrated their accounts of QoL in journals (n=9). This method proved to be extremely valuable as the participants answered specific questions of interest to the research and often provided supplementary data. (See enclosed CD for a copy of a journal, included with permission).

Trustworthiness of the Study

The researcher adhered to the following guidelines for quality in qualitative studies as described by Tracy (2010) in the table below:

Table 1

Criteria for quality in qualitative studies

Worthy topic	<ul style="list-style-type: none"> - Timely - expanding older white population. - Relevant - very little evidence was found of studies with a focus on older people's perceptions of QoL in care facilities. - Interesting - the study is considered as frontier research since a gap in the literature is evident.
Rich rigour	<ul style="list-style-type: none"> - Theoretical constructs - qualitative methodology supported by a phenomenological design and IPA analysis. - Date and time in field - the researcher spent 6 months at a residential care facility as a research intern. Data collection took place in various stages of the research process, with multiple data collection engagements.

	<ul style="list-style-type: none"> - Sample - every resident that was able to communicate congruently had the opportunity to share their perceptions. Sample included both male and female participants of various ages. - Context- multiple contexts to avoid biased results from one group of people who may not have a positive experience of their context or vice versa. - Data collection and analysis process - field notes complemented the data collection process. Analytic process was monitored by promoter.
Sincerity	<ul style="list-style-type: none"> - Self-reflexivity about subjective values bias and inclination - due to the prolonged time spent in the research field, the researcher was familiar with the day-to-day functioning of care facilities. Researcher acknowledges that personal perceptions of QoL differed to some extent from that which was reported. - Transparency about methods and challenges - some participants were more at ease in conversations than others, especially when they knew they were being recorded. Some preferred group activities as opposed to individual contact. Challenges occurred when appointments were cancelled and the researcher had to reschedule. Some participants also had the tendency to talk about matters unrelated to the research question. Building rapport with some was also challenging.
Credibility	<ul style="list-style-type: none"> - Thick descriptions - the researcher and field workers aimed to elicit additional explanations and verifications from participants when meanings were unclear. Multiple data collection techniques were useful in this regard. - Concrete detail - a detailed description of the research project was reported to the best of the researcher's ability. - Crystallisation - multiple types of data were gathered, various methods employed and numerous theoretical frameworks were considered.
Resonance	<ul style="list-style-type: none"> - Aesthetic evocative representation - the way in which the research is reported hopes to enlighten readers in such a way that they have a clear picture of the process in their minds. - Naturalistic generalisation - despite the inapplicability of statistical generalisation, knowledge gathered through qualitative methods can still be useful in other residential care facilities.
Significant contribution	<ul style="list-style-type: none"> - Conceptually - QoL is a multi-domain, objective and subjectively experienced context and cultural-specific phenomenon which develops and changes with age. - Practically - QoL can be enhanced when older people's preferences are considered.
Ethical	<ul style="list-style-type: none"> - Procedural ethics - complied with regulations of the ethics committee of the North-West University and the rules of ethical conduct described by the Health Professions Council of South Africa. - Situational sensitivity - adhered to addressing participants appropriately and taking their time into consideration as many

	<p>older people preferred not to be engaged in extramural activities in the afternoons when they have less energy.</p> <ul style="list-style-type: none"> - Relational ethics - kept a professional stance and regarded participants with dignity and respect. - Exiting ethics (confidentiality) - assured and maintained confidentiality by not discussing personal contributions and opinions of individuals with care staff or other residents.
Meaningful coherence	<ul style="list-style-type: none"> - Clarified whether the study achieved what it aimed to achieve in the conclusion. - Used methods and procedures that fit the stated goals. - Meaningfully interconnects literature, research questions/foci findings and interpretations.

Data Analysis

Analysis of textual data. The in-depth interviews and focus group discussions were recorded verbatim and transcribed. The narratives in the journals were already in textual format and suitable for analysis. Interpretative Phenomenological Analysis (IPA) was conducted as a means to analyse the data, since this method works well with texts generated by participants (Willig, 2001; Smith, Flowers, & Larkin, 2009). Meaning is central in IPA and the aim is to understand the content and the complexity of meanings rather than to measure frequency (Reason, 2003; Smith et al., 2009). IPA emphasises interpretation of individuals' perceptions of the topic of study and how these are reflected in themes and patterns in the data.

Line-by-line analysis of the interview transcripts produced a set of themes containing the reflections of the participants. Additional extracts resulting from focus group discussions and the narratives in the journals were checked against the themes that emerged from the interviews to ensure relevance of the analytic framework and to identify new themes. This developed a 'dialogue' between the researcher, coded data and the psychological knowledge that applied to the patterns that emerged. Lines of argumentation were identified in terms of the relationship of patterns to each other and verified against further extracts. Emerging

themes were revised until the analytic framework usefully accounted for the participants' understandings and no further themes could be identified. The main themes are discussed below.

Findings

In QoL research the names and labeling of domains vary almost incessantly between studies. Many of the domains of QoL described in the literature were confirmed by the participants in this study, namely health status and access to health care resources; capacity to carry out activities of daily living, doing something constructive; the availability of opportunities to pursue recreational interests; social functioning in relationships and friendships; access to nature, standard of living; as well as security and general well-being (Bowling et al., 2002; Cummins, 1996; Farquhar, 1995; Hambleton et al., 2009; Kane, 2001; Kane & Kane, 2001). However, in this study new knowledge was revealed in terms of a more nuanced understanding of certain aspects (that have received less attention in the QoL literature) that inform the nature of QoL for this group of older people.

Table 2 presents the themes and subthemes distinguishing the nature of QoL as described by older people in the particular social context from general views on QoL.

Table 2.

Themes and subthemes informing the nature of QoL

Themes	Subthemes
Facilitating role of spirituality	Spiritual worldview informs QoL Coping with adversity Mindfulness towards others
QoL in interpersonal contexts	Quality relationships with family and close friends Proximity of relationships Reciprocal caring relationships
Self-regulation	Health Finances Behaviour
Transitional nature of QoL	Former QoL: 'Doing' things to have things Current QoL: 'Being' content in current circumstances

Facilitating Role of Spirituality

The way in which older people referred to spirituality revealed the underlying importance of their belief system in their day-to-day lives. In the opinion of many participants, spirituality informed their QoL and enforced functional coping strategies in terms of dealing with adversities in their present circumstances. Their spiritual worldview also influenced them to be mindful of others.

Spiritual worldview informs QoL. A number of participants referred to their spiritual belief systems as the source of their QoL. Spirituality provided the participants with a sense of purpose as they had something to live for: God made it possible for them to enjoy QoL. One older person explained: *'Every person that doesn't live for Him with their whole heart, or live through Him is unable to enjoy the QoL that only He gives'* [interview]. According to another, QoL is the result of God's involvement in the detail of their lives, for example *'QoL for me is to be able to get up every morning, and to know that He will help me in every situation and make my path straight'* [interview]. Furthermore, the measure of QoL

was also graded against a spiritual worldview as expressed in the following quotation: '*QoL is experienced to the greatest extent when Jesus Christ is the Alpha and Omega in your life*' [journal].

Coping with adversity. Participants also relied upon their spiritual worldviews to cope with adversity in their lives. This is reflected in the following quotation, where life is negotiated with God to be able to cope with determined outcomes: '*Throughout life and to this day the Lord has helped me, when I was pushed into the theatre I made right with Him. I told Him that I would accept whatever the results turned out to be*' [interview]. In a focus group discussion participants reflected on how they felt extremely comforted by *having God* and to know *He will help them and always be with them*.

Mindfulness towards others. For some participants their spiritually-informed worldview motivated them to be mindful of others, which made them reach out to other people in need, in or outside of the facility. A participant reflected [in a journal]: '*Because of Him I still feel I want to do more for others, the sick , old people like myself and little children and babies*'. In a focus group it was mentioned that the participants held Bible study groups in which they served one another in terms of exchanging prayer requests and relating to one another. Aspects of providing financial support to those less fortunate were also discussed in the focus group. One participant stated that '*we should give to others what they DO NOT deserve, because that is what God gave to us*' [focus group]. For many of these participants their spirituality inspired them to be good to other older people and people in general.

QoL in Interpersonal Contexts

The participants also emphasised the importance of social support through quality and reciprocal caring relationships in a variety of interpersonal contexts. Social rapport can be described as the web of social relationships that surrounds an individual and varies from person to person depending on family size, frequency of interpersonal contact and living arrangements. The importance of relationships in later life has been widely reported on in the literature as a domain of QoL. Specific relational aspects of the group under study were expressed as follows:

Quality relationships with family and close friends. Participants clarified what they meant with ‘quality relationships by making a distinction between knowing people and standing in a relationship with them. Please consider the following quotation from an interview: *‘I have my close friends, many of them do not live here (in the facility). We have known each other for a long time and went through many things together’*. When the participant was asked if she had good relationships with people in the facility she replied: *‘You get to know the faces of people and they are mostly friendly, but not many are open. You hear of residents who get sick or of others that go away to visit but people are not really involved in each other’s lives’*. From a focus group discussion it was also gathered that *‘it’s difficult to make good friends here’* (in the facility) and that residents *‘keep to themselves’*, *‘stay in their rooms’* and *‘value privacy’*. Quality relationships in the facilities were mostly formed with neighbours or other residents who participants had known for a long time or those with whom they have something in common (belonging to the same church, reading groups, walking groups, etc.).

The majority of participants viewed their relationships with children or other close family members such as grandchildren or siblings (where applicable) as very important. At

the loss of a spouse a conversion of primary relationship status seemed to occur towards family (mostly children) or close friends for support, a sense of camaraderie and positive interaction. Participants regarded relational ties with their families as a large part of their QoL in later years. A participant wrote [in a journal]: *'The privilege of healthy family relationships and the relationship with our children that often visit, affords us QoL now'*. The data further revealed that older people attach even more value to interaction with family in their later years, as noted in the following quotation: *'The opportunities that we now get to visit our children are becoming more and more precious as this keeps us going'* [interview]. These important relationships motivated them to carry on and go forward in life.

Quality relationships were expressed in terms of experiencing the relationship as nurturing, where the older people felt that their family still cared for them and wanted to spend time with them. In a focus group discussion it was stated that *'It is always nice when my daughter and the children (referring to grandchildren) come to visit me here.... When I go to visit them she is always busy with the kids and their sport and we rarely sit down together, but when they come here, they spend time with me'*.

Proximity of relationships. The quality of relationships seemed to be related to the proximity of relationships and the opportunity of frequent interaction with important people, including family, other residents at the care facility, long-time friends residing outside of the facility or close friends from church. Some participants whose children lived far away or in other countries, attached greater value to friendships and were closer to others in their immediate environment. A quote from a focus group discussion revealed that *'many people's children live far away'*, implying that interaction was limited (e.g. *'we see them once or twice a year'*). In this sense the support of others in the same situation is comforting to them (e.g. *'the good thing about living here is to have people nearby that understand your situation and to be there for one another'*). Quality relationships with friends outside of the facility were

also regarded as valuable. A female participant stated in one of the interviews that *'I have a friend, a man who doesn't live here (in the facility). We go to the movies together and have coffee. This is precious to me at our age'* [interview].

Reciprocal caring relationships. Participants expressed a need for reciprocal caring relationships in which they felt highly valued and were not only at the giving end but also received care: *'I feel happy when I am able to help other people...there are always others here that also help me'* [focus group]. The importance of reciprocity was highly evident from participants who felt that they did not receive friendship or support (depending on the nature of the relationship) to the same extent as they were willing to extend it, as is evident from the following two quotations [journal and interview respectively]: *'In this facility many people come across your path, some of them have been broken down by the years and they only want to talk about themselves and their own past; I never get a turn. I just don't know whether I want to give myself for this, I want people in my life who are willing to listen'*.

Self-regulation

Self-regulation was found to be an important construct for understanding the nature of QoL. Many responsibilities are taken away from older people when they go to residential care facilities. Behavioural aspects, health and finances were specifically mentioned as things that participants were prone to regulate to a certain extent. The importance of regulating behavioural aspects is reflected in the following: *'I know I have to change my attitude toward the people here'* [journal], and *'quality of life is a mindset... you choose if you are happy or not'* [focus group]. Self-regulation in terms of health aspects can be noted from the following quotations: *'I believe that I have to manage my health, to rest enough and relax, control my appetite and do some exercise'* [journal], and *'I regret very much that I started to smoke. I know these poison sticks (cigarettes) are no good and I know I should quit for my own sake'*

[interview]. With regards to financial regulation a participant stated: *'things are getting more and more expensive, as also the cost of living here, and it's difficult to save but I try to do it every month'* [interview].

Transitional Nature of QoL

The nature of QoL was described as a construct with transitional properties. Some domains of QoL remained unchanged across the lifespan, mainly those of universal meaning such as the availability of opportunities to pursue recreational interests; access to nature; standard of living; security; and general well-being. However, from the narratives a noticeable difference emerged in the way that the participants' currently perceived QoL, compared to their former views of the construct. Domains such as spirituality, health and nurturing relationships were seldom mentioned as important for QoL when the participants were younger, whereas they were now deemed vital. According to the participants, former QoL revolved mainly around 'doing' things to obtain or have things, and current QoL in 'being' content with current circumstances.

Former QoL: 'Doing' things to have things. For the participants, QoL in their earlier years was expressed in terms of the ability to do things in order to have things. The domains of importance to former QoL were expressed as marital life, family life, career success, social engagements and financial success. These domains varied to a great extent between male and female participants. A male participant wrote: *'My intellect, choice of friends and socio-economic status all contributed to my quality of life. It was important to have a tertiary education and a good job. The choice of life partner and wealth was also very important'* [journal]. An older woman stated: *'My husband and our children, and hosting our extended family and friends on our farm defined my QoL ... Personal development also gave quality to my life, like being a mother and caring for my family; things that were important to me'* [interview].

Men were mostly focussed on career, money and self-attainment: *'I enjoyed being a teacher, keeping fit and expressing myself through sport'* [focus group], and *'Everything revolved around money and being able to provide for my family; because of this it was essential to have a good job'* [journal]. On the other hand, women attributed their QoL to the success of their family life, self-image, home and upbringing of their children: *'I always wanted to look nice and be thin then, I enjoyed keeping a house and building new friendships'* [journal]. Another woman stated: *'the kids needed to be happy and do well in school so your life was basically made up of caring for them and making sure they had everything that they needed'* [interview].

Current QoL: 'Being' content in current circumstances. It appeared that older people's views (males and females) converge in their later years and the participants were more focussed on 'being' than on doing many things. Their perceptions changed on what they considered to be meaningful. A participant described his current view on QoL as follows: *'Things which now define my QoL are to live in peace with my wife, using the abundance of time that I have to explore spiritual things, good relations with our children and others, and good health is also essential'* [journal]. An older woman's perception of her current QoL complied with the previous statement: *'To know God is a profit, for me the contentment of life now lies in walking with friends and making those happy that are close to me'* [interview]. Current QoL seemed to be more largely informed by acts that gave meaning to their lives, such as relaxing, having a good time with loved ones and being considerate of others. One older person wrote [in her journal]: *'It is important to me that my daily activities will count for eternity, and that I don't merely stay busy just to pass time but will do things that will have a positive influence in my own and other's lives'*. The transcendent nature of QoL can also be seen in the following quotation where a participant emphasised the continuous need for new experiences and challenges: *'New challenges are essential for QoL,*

one has to try new things never yet experienced for the sake of your body and spirit, or just new things in the place of things that you are no longer able to do because of age. I easily get depressed if I don't practice these principles' [journal]. It emerged that older individuals still have the need to learn, develop and discover. Those factors that used to give them QoL are replaced by new experiences that older people are capable of performing.

Discussion

The nature of QoL is contextually grounded. The older white generation in South Africa grew up with a well-defined, organised and conservative religious system (Codrington & Grant-Marshall, 2005; Thompson, 2000). This could be the reason why participants identified spirituality as the core of their QoL. Spirituality was identified on two levels - in relation to the self where individuals' spiritual worldviews informed their QoL and helped them to cope with adversities, and in relation to other people. The literature confirms that people turn to spirituality as a way of coping with external crises and internal conflicts (Sulmasy, 2002; Roos, 2013). In relation to other people, participants reported that their spirituality motivated them to be thoughtful of others. Mindfulness is defined as the process of becoming aware of the environment and one's reaction to it (Langer, 1989; Langer, 2005). According to Carson and Langer (2006) a mindful individual is actively engaged in the present and sensitive to both context and perspective. Participants' mindfulness enabled them to react to their internal states as they became aware of the needs of others in their immediate context/environment; an awareness they could then act upon. Although the literature on QoL of older people recognises spirituality as an important area of life for older people (Kane, 2001; Sulmasy, 2002), a UK study by Bowling (1995) found that only 2% of 409 older participants regarded spirituality as important, compared with other domains of QoL such as

health (54%) and relationships (39%). For the participants in this study spirituality was essential to their QoL.

QoL was described in terms of the availability of quality relationships that offered social support, security and mutual affection and reciprocity; all essential to QoL. According to Antonucci (2001) as well as Dhurup and Surujlal (2009), social support stems from social exchange (creation of networks which are resource-dependent) and social equity (equal benefits are experienced by the both parties, resulting in reciprocal relationships). The findings of this study correlated with that of Farquhar (1995), who proposed that the QoL of older people revolves around family, social activities and other social contacts. Aldwin and Gilmer (2004) stated that the quality and meaningfulness of relationships are estimated by the satisfaction with the state of the relationship and the availability of help. According to Krause and Shaw (2000), perceived support is of greater value to the older person than received support. In other words, it is not what is provided that is important but the belief that help will be available when it is needed. The proximity of children and other relatives, as well as contact with friends in and outside of the facility emerged as important for older people to feel established in their social context (Victor, Scambler, & Bond, 2009). Their QoL was also informed by the reciprocity in relationships. Reciprocity refers to the give and take of assistance from one person to another (Antonucci, 2001). Many participants of this study endorsed helping or supporting others as their contribution to quality relationships. However, many also revealed that the reciprocity they experienced in their relationships was not satisfactory and they felt like the only giver in the relationship.

Self-regulation can be thought of as a self-guided process that focusses on a person's cognitions, affect and actions, as well as environmental features to assist with the attainment of goals (Boekaerts, Maes, & Karoly, 2005). The transition from community living to a residential care facility has the effect that residents have fewer responsibilities in terms of an

occupation, family life roles, a demanding schedule, cooking, domestic tasks, gardening, maintenance of a property and a car (for some). Residential living also decreases the availability of choices. Self-regulation was found to inform the participants' QoL because it awarded them with a sense of control over at least some aspects in their lives. Brown and Ryan (2004) found that the perceived ability of older people to change or have an influence on a situation affected their behaviour, as well as their physical and mental well-being. According to Leventhal, Forster and Leventhal (2007), the self-regulation of older people is built around the motivational characteristics of behaviour. Therefore, their ability to regulate certain areas in their lives and seeing the results keeps them motivated. The importance of being able to regulate behavioural aspects, health and finances emerged from this research. When older people were still able to regulate these areas, they reported having better QoL.

The transitional nature of QoL was linked to changes during the course of life. Older people linked their former QoL with being actively involved in order to attain things such as good socio-economic circumstances, career satisfaction and a functional family life. In their current life phase, their QoL was expressed as a state of being content with where they currently found themselves and being engaged in things which had meaning to them presently, such as their spirituality, relationships with others and working toward the goodwill of others. Divergent approaches to QoL were noted between men and women in their younger years. These approaches have been said to converge in later life (Arber, Davidson, & Ginn, 2003). This agreed with the findings of Baltes and Smith (1999), who stated that younger persons see their lives largely ahead of them and they are prone to actively engage in things that permit them to develop a life that reflects their aspirations and abilities. In contrast, many older persons see their lives as coming toward a conclusion and seek to make meaning out of their life histories, while conserving resources and creating family legacies.

Implications and Recommendations

The experience of people's QoL cannot be generalised – neither on a developmental level nor on a personal level. Older people themselves are the best appraisers of the value of aspects that allow them to lead good lives (Hambleton et al., 2009). It is recommended that care facilities should uncover what residents consider to add quality to their lives and to build on such aspects. Such an approach is in line with the opinion of Csikszentmihalyi (1999), who suggested that intervention does not merely entail fixing what is broken but instead nurturing what is best for the individual concerned. It is recommended that a smaller focus should be placed on merely keeping older people busy in facilities and to create spaces and opportunities for older people to be together in a meaningful and caring manner. The implications for future research are that little formal research has been done to explore the preferences of and differences between older people's QoL in residential care facilities. It is recommended that various aspects that contribute to- and inhibit the QoL of older people in these settings should be further explored.

Limitations

Qualitative research is context-specific and the findings of this study should not be generalised to other settings. The exploration of this study was limited to information given by the participants during the interviews, through journal inscriptions and during focus group discussions. Limited resources concerned with the QoL of white older people were available in the South African literature and therefore the review drew primarily from multidisciplinary national resources and from the broader international literature.

Conclusion

This study revealed valuable insights with regards to the nature of QoL for older people in South African residential care facilities. Spirituality facilitated various eudemonic traits (developing to their fullest potential) such as coping, making life adjustments and being mindful of the needs of other people. The importance of quality, close (proximity) and reciprocal relationships emerged as important for QoL. Self-regulation is furthermore associated with enjoying QoL. The nature of QoL was seen to be transitional throughout the ageing process, the focus shifted from doing things in earlier life in order to have things, to a state of contentment with being meaningfully engaged and doing things of value.

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CHAPTER 3

ARTICLE 2

CONTRIBUTORS TO AND INHIBITORS OF QUALITY OF LIFE FOR OLDER PEOPLE IN RESIDENTIAL CARE FACILITIES IN SOUTH AFRICA

Contributors to and Inhibitors of Quality of Life for Older People in Residential Care Facilities in South Africa

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Abstract

This qualitative study explored the contributors to and inhibitors of quality of life (QoL) of older people living in residential care facilities in South Africa. A purposive sample (n=54) of older people who were still able to communicate congruently participated in the research (male, n=10 ; female, n=44). No participants were frail. Data collection took place in rounds, by means of qualitative techniques including interviews, the use of journals and the Mmogo-method[®]. Textual data were analysed by means of interpretative phenomenological analysis and the visual data through a visual analytic method. The study revealed the QoL domains pertaining to this specific group of older people as spirituality, health, meaningfulness, autonomy, sense of place and relationships. The contributors and inhibitors concerned with each domain were also explored. It is recommended that residents, care givers and the staff of facilities be made aware of the contributors to QoL. Psychosocial intervention ought to focus on maintaining and enhancing contributing properties to allow older people to deal with the inhibitors in a constructive manner.

Keywords: Quality of Life; older people; QoL contributors; QoL inhibitors; residential care facilities, Mmogo-method[®]

Introduction

A growing ageing population in South Africa has led to a growing demand by older people to reside in residential care facilities. Van der Walt (2011) provided an overview of the situation of older persons in South Africa and indicated that the country has one of the most rapidly ageing populations in Africa. Currently there is no standard numerical criterion for the classification of people as “older” but the United Nations (2007) arrived at a point of agreement by accepting a cut-off age of 60 and older years to refer to those of the older population. South Africa had 3.5 million persons above the age of 60 in 2008 (7.3% of the total population) and it is projected that this figure will double to 6.5 million by 2015 (10.5% of the total population). According to the Population Reference Bureau (2012), 86% of all older persons in Southern Africa reside in South Africa. Despite the demographic impact of the HIV epidemic, Joubert and Bradshaw (2004, 2006) have indicated that the South African population is to continue ageing over the next two decades, with more than one and a half person in 10 being 60 years or older by 2025.

Older people reside in residential care facilities for various reasons such as security, services, financial implications, long-term care needs as well as socialising with peers (Joubert & Bradshaw, 2006; Lee, Yu, & Kwong, 2009). Access to residential care facilities for older people of all race groups was only amended following the 1994 elections in South Africa which brought an end to apartheid. Prior to this, members of other race groups (apart from whites) did not have access to such facilities. Despite transition acts installed by government with a view to integrating all race groups into these settings, an audit by the Department of Social Development (2010) revealed that the majority of facilities (79%) are concentrated in metropolitan formal areas or small urban formal areas. Only 5% of residential care facilities are situated in informal or squatter areas, while 16% are found in rural areas. Africans comprise 67.7% of the population of older persons in South Africa but they reside

mostly in the rural areas. While whites comprise 22.5% of the older South African population, which is more than double their proportion in the general population, members of this group reside mostly in metropolitan or urban areas. The same audit revealed that almost 90% of all care facilities were inhabited by white South Africans. For this reason the present study will focus on this group of older people.

Research has found that older people in residential care facilities are more likely to experience reduced quality of life (QoL) due to changes in the living environment, altered social interaction patterns and deteriorating health (Joseph, 2006; Lee et al., 2009). Widespread stigmatisation concerning residential care facilities frequently attaches a negative connotation to this type of living environment as many older people grow weaker quite rapidly after being institutionalised. For example, a study by Lee, Woo and MacKenzie (2002) found the transition from independent living to living in an institution to be challenging, as various intrapersonal and interpersonal sacrifices are required in order to adapt to the new setting. Privacy is often compromised and physical living space is drastically reduced. QoL in care facilities is furthermore found to be a significant predictor of mortality, physical dependence and service utilisation in residential care facilities (Dorr et al., 2006).

QoL as a construct is regarded as multi-dimensional, although the number and nature of the dimensions remains controversial (Hambleton, Keeling, & McKenzie, 2009). QoL and its properties have been widely studied across many disciplines with little indication of its exact meaning. Furthermore, there is growing recognition that the study of QoL of older people is complex and requires greater transparency in terms of context, population dynamics and research aims, methodology and theoretical grounding (Hyde, Wiggins, Higgs, & Blane, 2003). Since there is little consensus on how QoL is defined by older people in care facilities (Kane, 2003; Lee et al., 2009), this study adopts the definition proposed by the World Health

Organization Quality of Life group (WHOQOL, 1993) that QoL is a multi-dimensional concept which involves an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. Within the discipline of psychology, QoL is largely embedded in positive psychology (Carr, 2004). Positive psychology has been defined as the scientific study of optimal human functioning and aims to understand human strengths as much as human weaknesses in order to assist people psychologically and physically (Dunn & Dougherty, 2005; Linley & Joseph, 2012). However, Seligman (2002) stated that a distinction should be made between the pleasant life (hedonic approach in positive psychology) and the good life (eudemonic approach in positive psychology). In his opinion the pleasant life may be achieved by pursuing positive emotions. In contrast, the good life involves using signature strengths to obtain gratification in important areas of life.

Various researchers have proposed that the process of ageing has become less intimidating and various strengths have been associated with ageing, such as intrinsic motivation and emotional regulation (Oeppen & Vaupel, 2002; Wachter & Finch, 1997). Furthermore, older people have also shown gains in physical and mental fitness (Lindenberger, Marsiske, & Baltes, 2002), cognitive reserves are better preserved (Singer, Verhaeghen, Ghisletta, Lindenberger, & Baltes, 2003), they have increased emotional intelligence and wisdom (Baltes & Staudinger, 2000) and have acquired the ability to regulate their internal adaptability (Staudinger, 2001). Despite all these strengths rendering the ageing process more effortless and undemanding on the older person, it is still not clear to what extent these strengths and possible others apply to and are employed by older people in residential care facilities to improve their life.

The many studies that have been conducted by those in the health-related discipline of nursing on the QoL of older people in long-term care facilities deserves to be acknowledged

(Redfern & Ross, 2006). Such studies tend to focus on the quality of health care of frail older people. While the traditional outcome measures used in health care research (mortality and morbidity) have predominantly been used in long-term care evaluation, quality of life has also been recognised as an important outcome in recent years (Cotter, Salvage, Meyer, & Bridges, 1998). Research findings on QoL in care facilities (from international resources) are contradictory and confusing. A study by Kane (2001) revealed a high level of satisfaction with QoL among semi-dependent residents (receiving assistance with some activities of daily living). In contrast, the work of others has reported on the QoL of older people in these settings as poor (Joseph, 2006; Lee et al., 2009). In a study by Kane, Kane and Els (2002) with a large sample of ill persons over the age of 70, 29% indicated that they would rather die than enter a care facility. Other surveys amongst community-dwelling older people have also revealed a strong aversion to care facilities (Levasseur, St-Cyr Tribble, & Desrosiers, 2009). Less is known about the more functional (those that are not ill or are independent) older people that reside in facilities, thus warranting further investigation (Kane & Kane, 2001). Furthermore, in the international literature a limited number of qualitative studies have been concerned with the QoL of older people (Bowling, Bannister, Sutton, Evans, & Windsor, 2002; Gabriel & Bowling, 2004; Bowling, et al., 2003; Farquhar, 1995). QoL research in South Africa has largely demonstrated the same trends, the majority of studies having been conducted quantitatively and on sections of the overall population not explicitly focused on older people. South African studies have also largely been conducted from socio-economic or health perspectives (Møller, 2000; Møller, 2004; Ferreira, Lund, & Møller, 1995). Qualitative studies on the older South African population which have been conducted from a psychological stance are scant. The necessity of studying QoL from the perspective of the individual has been advanced by Halvorsrud and Kalfoss (2007); these authors being of the

opinion that the lay views of older people have not been given enough consideration when conceptualising QoL.

Contemporary conceptualisations can sometimes convey a rather idealistic image of QoL. Little formal research has been done to explore the preferences of and differences between older people's perceptions of QoL in residential care facilities. The current study endeavoured to move away from positivity bias which has also been reported as problematic in research with older people. Supposedly older people have a tendency to accentuate only the positive as a by-product of a heightened awareness of their emotional state when reflecting on subjective phenomena, according to Fernandes, Ross, Wiegand and Sheyer (2008). The research question that guided this study is: what contributes to or inhibits the QoL of older people in residential care facilities? By exploring various aspects that contribute to and inhibit QoL, a more balanced conceptualisation ought to be obtained. According to Fry (2000) a balanced conceptualisation of QoL will be considerate of influences on QoL. Furthermore, new knowledge in the field of QoL requires a deeper understanding of the views and experiences of older people themselves.

Aim of the Study

Previous research in the South African context has rarely included the personalised accounts of older people regarding their perceptions of QoL in residential care facilities. This study aimed to explore what contributes to and inhibits the QoL of older people in this context. This research hopes to provide residential care facilities and practitioners in the field with some recommendations on how to maintain and enhance contributing aspects of QoL and to deal with the inhibitors in a constructive manner.

Research Methodology and Design

A qualitative approach was considered the most appropriate methodology for this study. Qualitative research methods enable inherent participant-generated meanings to be captured in conversations, expressions or text (Denzin & Lincoln, 2005). Therefore, evidence gathered through qualitative methods can be used to explain the meaning that older persons attach to their experiences of QoL (Snape & Spencer, 2003). A phenomenological design was used to explore the aspects that contributed to or inhibited older people's experience of QoL. According to Terre Blanche, Durheim and Painter (2006), the meaning of human creations, words, actions and experiences can only be contained in relation to the context in which they occur, in both social and societal contexts. By applying this design, the researcher aimed to understand the perceptions that people have of their context-specific circumstances, and also to describe what participants have in common in their experience of QoL in their later years (Creswell, 2007; Giorgi & Giorgi, 2008).

Research Context

The research context can be sketched against the backdrop of facilities that offer independent living, assisted living and frail care living arrangements (Department of Social Development, 2006). Four independent residential care facilities formed the basis for participant recruitment and data collection. The motivation for more than one site was to obtain data from multiple contexts to cover an array of aspects that could possibly influence QoL (Mouton, 2009).

Two of the four facilities offered a broader range of recreational and social activities in which residents could participate (such as weekly trips to the local mall, monthly tea gatherings for residents celebrating their birthdays and performers once or twice annually). All facilities had libraries, TV rooms, church services and sufficient walking space for older

persons on the grounds of the facility, as well as gardens. A social worker was appointed at each facility, and the remainder of staff at the facilities mostly included care givers, nursing staff and operational staff (manager, office personnel, kitchen staff and cleaners).

Selection of Participants

Qualitative research uses non-probability sampling methods for selecting participants (Ritchie & Lewis, 2003). A homogenous sample was sought in that the participants belonged to the same subculture and shared various characteristics, for example inhabiting a shared living space. Purposive sampling allowed an in-depth exploration of participants' experiences in their natural living environment (Patton, 2002). Willing participants of both genders, between the ages of 62 and 95 years who were still able to communicate congruently and fully understood the purpose of the research participated in various rounds of data collection. Participants' marital status did not form part of the selection criteria, although it is worth mentioning that all the participants were widowed except four individuals who still had spouses and one individual who never married. Afrikaans was the mother tongue of all the participants. The majority of white older people prefer institutional living and for many older people in this racial group this is their only option. Fifty-four (male, n=10 ; female n=44) older people participated in this qualitative inquiry. None of the participants lived in frail care units although some received help with activities of daily living. The majority of participants resided independently (implying they were still fully capable of taking care of themselves) at the residential care facilities.

Procedure

Permission was obtained from the Ethics Committee of the North-West University, Potchefstroom. This research obtained ethical permission under a larger project titled: *An exploration of enabling contexts* (O5K14). The ethical requirements stipulated by the Health Professions Council of South Africa (HPCSA, 2008) were also adhered to.

The first author did the following to ensure that the relevant ethical principles were adhered to: Permission was obtained from the managers of the residential care facilities where data were collected. An initial meeting was held with all participants to explain the purpose of the research. Willing participants gave written informed consent. Data collection times were scheduled at the convenience of the participants and they were also informed that they could withdraw from the study at any stage. Participants were assured of the confidentiality and anonymity of their contributions and the data remained in the safe-keeping of the first author only. The first author and three intern Masters students in Psychology were involved with data collection. The interviews, focus groups and Mmogo-method[®] discussions were recorded verbatim and transcribed. The narratives in the journals were already in text format. Data were analysed by the first author and peer reviewed by the second author.

Data Gathering

Multiple methods of data collection were employed to gather a rich data set of information. Please consider Figure 1 for the layout of the data collection procedures:

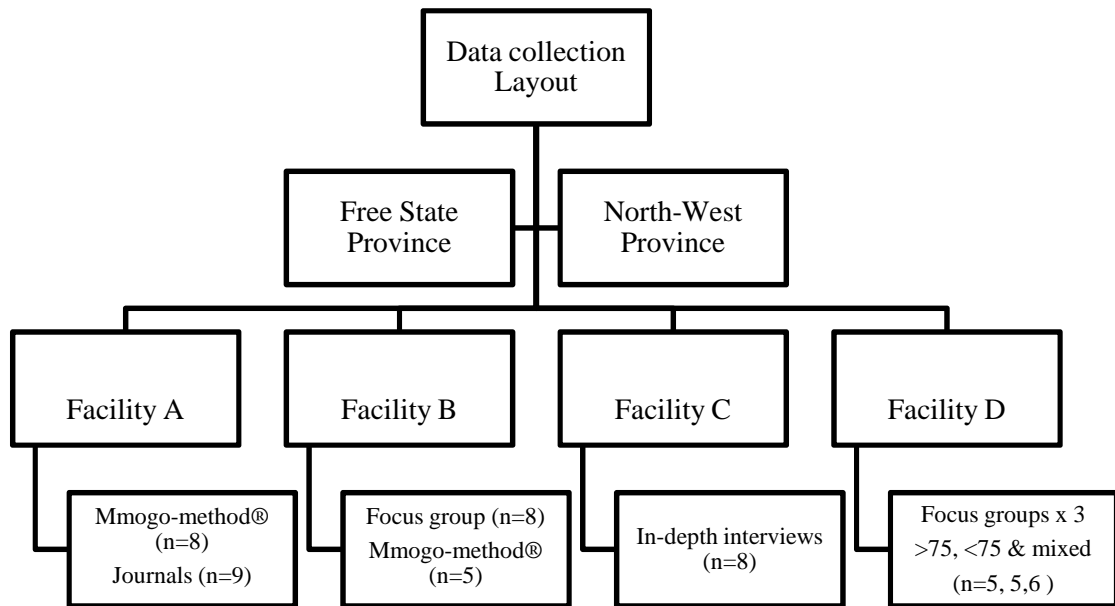


Figure 1. Layout of data-collection procedures.

The Mmogo-method[®] and in-depth interviews, focus groups and journals formed the qualitative toolkit for this enquiry. On the scheduled day of the data collection, the participants were reminded of the research objectives and the procedures concerned with each data collection method were explained.

The Mmogo-method[®]. This method of data collection was conducted at two facilities where 13 older women constructed their experiences and perceptions of QoL. The one group was comprised of eight participants (ages ranged between 60 years and 73 years) and the other group had five participants (ages ranged between 70 years and 87 years). Participants were told that they would be required to make visual representations of their experiences of QoL using a visual projective data gathering instrument. The Mmogo-method[®] uses the subjective nature of people's frame of reference to obtain insight into their subjective lived experiences (Roos, 2008). With the Mmogo-method[®], the participants used clay, beads, and sticks to construct their visual representations based on an unstructured request: *'Please use*

the material in front of you and construct a visual representation of anything that could tell me more about your QoL'. In participating in the Mmogo-method[®], participants sat around a table where they constructed their visual representations simultaneously. After all participants had completed their representations, the researcher had a discussion with each participant about their visual representation and the meaning thereof. These discussions provided the first author with additional information and with the opportunity to verify the data.

In-depth interviews. Data were also obtained from participants by means of interviews in which the contributors to and inhibitors of QoL were discussed. Working through the manager of a facility, eight (n=8) older people availed themselves for in-depth interviews; four being younger than 75 years and four older than 75 years. With qualitative inquiry these interviews are usually semi-structured and the interviewee is afforded flexibility when open-ended questions are posed to the participants (Maree, 2007). All of the participants preferred to have the interviews conducted in their rooms or apartments. The interviewee made an appointment with each participant at a time that was convenient for the interviewee. Participants answered a set of predetermined questions. Questions posed to participants in this particular study included: *'Please tell me more about your quality of life; What contributes to your quality of life?; and What inhibits your quality of life?'*. Banister, Burman, Parker, Taylor and Tindall (1994) maintain that interviews are useful because they permit social researchers to explore issues that are too complex to investigate through quantitative means.

Focus groups. The aim of a focus group is to encourage self-disclosure in order to gain more insight into the perceptions, attitudes and opinions of participants (Creswell, 2007). The same open-ended questions were explored that formed the basis of the in-depth interviews. The utilisation of this technique was motivated by the thin descriptions that emerged from the interviews. The interview participants were eager to engage in lengthy

conversations about their lives and circumstances but these conversations did not yield sufficient information or descriptions. Focus groups were conducted at two facilities and consisted of one larger group of mixed ages (n=8) as well as three smaller groups (n=5,5,6) comprising an older group (>75 years, n=5), a younger group (<75 years, n=5) and a group of mixed ages (n=5). Focus groups give the researcher more control over the direction in which the questioning should go, and, by asking open-ended questions, data can surface in an inductive manner (Creswell, 2007).

Journals. Nine participants shared their opinions of QoL as well as the contributors to and inhibitors thereof by means of journal inscriptions. Journaling is a written format of narrative story telling (Creswell, 2007). Instructions to participants were printed in the journals and read as follows: *Please define quality of life in your own words*; *What are the things that contribute to your quality of life*; *What are the things that inhibit your quality of life*; and *Please feel welcome to share any additional thoughts on quality of life*. According to Alaszewski (2006), the whole idea of participants writing their thoughts down is to have the opportunity to return to the written text and supplement it with additional thoughts or information.

Data Analysis

Data were analysed both visually and textually to create thick descriptions of the participants' perceptions. Thick description, as proposed by Geertz (1973), entails an account of a phenomenon that is coherent, gives more facts and empirical content and also interprets the data in the light of other empirical information in the same study.

Visual data analysis. The recommendations of Roos (2008) were adhered to in terms of analysing the visual data obtained from the Mmogo-method[®]. According to Roos (2008), visual representations reflect the conscious meaning that participants project about a

particular phenomenon. The researchers analysed the visual representations by observing the nature of the specific objects that the participants constructed; the relationship between the objects, for example the distance between the objects; the actions in which the objects are involved; the relational context as well as the broader environment in which the objects are placed; and how the objects are related to the research question. The themes generated by the visual analysis of the representations were linked with themes that derived from the analysis of the textual data. This added to the trustworthiness of the data.

Analysis of textual data. The interpretative phenomenological analysis of data is concerned with the detailed examination of human lived experience. This method of analysis aims as far as possible to express the experience in its own terms rather than according to a predefined category system (Smith, Flowers & Larkin, 2009). In the present study, several important themes were identified in relation to QoL domains, as well as contributors to and inhibitors of QoL. Line-by-line analyses of the interview transcripts produced a set of themes containing the reflections of the participants. Additional extracts resulting from focus group discussions, discussions after the Mmogo-method[®] as well as the journal narratives were checked against the themes that emerged from the interviews to ensure relevance of the analytic framework and to identify new themes. This developed a ‘dialogue’ between the researcher, the coded data and the psychological knowledge that applied to the emerging patterns. Lines of argumentation were identified in terms of the relationship of patterns to each other and were verified against further extracts. Emerging themes were revised until the analytic framework usefully accounted for the participants’ understandings and until no further themes could be identified.

Trustworthiness of the Study

The process of crystallisation in qualitative studies yields a more detailed and rich representation of the phenomenon under investigation (Ellingson, 2009). Crystallisation was used to ensure trustworthiness as this method allows for the clearest possible picture of the research topic to be constructed by obtaining multiple perspectives of QoL (Henning, Van Rensburg, & Smit, 2005). Crystallisation is a methodological framework for bringing together different forms of data and analysis as well as different genres and forms of sense making within interpretive methodology (Ellingson, 2009). In the present study this was achieved through various data collection techniques, using two methods of data analysis (textual and visual) and reporting the results using the visual representations and verbatim conversations in the form of textual data. The contributors to QoL were discussed with ease in the focus groups (also in the Mmogo-method[®] group settings). However, the bulk of information on QoL inhibitors was often elicited only in the in-depth interviews and journals because some of the older people were reluctant to show (what they consider) weaknesses in a group context. The visual representations furthermore elicited rich data about a specific participants' understanding of QoL. The journal narratives were extremely valuable as they answered specific questions of interest. Themes were extracted from these narrative accounts.

Findings

The table below shows the main themes and subthemes elicited from the data. The main themes were identified in terms of domains that comprise QoL in the opinion of the study's participants. The subthemes demonstrate the contributors to and inhibitors of each domain respectively.

Table 1

Domains of QoL and the contributors to and inhibitors thereof

QoL Domains	Contributors	Inhibitors
Spirituality	<ul style="list-style-type: none"> - Supporting relationship with God - Coping mechanism - Spiritual support network 	<ul style="list-style-type: none"> - Traditional spiritual rituals and practices
Relationships	<ul style="list-style-type: none"> - Close familial relationships - Close social relationships - Positive relationships with staff 	<ul style="list-style-type: none"> - Loss of relationships due to death - Loss of relationships due to proximity - Conflict in relationships
Health	<ul style="list-style-type: none"> - Physical ability - Independence - Cognitive abilities 	<ul style="list-style-type: none"> - Reduced physical and cognitive abilities - Pain - Long-term illness and death
Meaningfulness	<ul style="list-style-type: none"> - Purpose in life - Feeling useful through helping others - Meaningful activities and new challenges 	<ul style="list-style-type: none"> - Boredom
Sense of place	<ul style="list-style-type: none"> - Access to nature - Privacy - Safety and security - Physical structure of the facility 	<ul style="list-style-type: none"> - Loss of privacy - Financial constraints - Isolated from broader society
Autonomy	<ul style="list-style-type: none"> - Control - Self- regulation (behavioural, physical, financial) - Individuality 	<ul style="list-style-type: none"> - Negative attitude - Loss of control and independence

Spirituality

In this study most of the participants expressed their spirituality in terms of two dimensions; the first of these involving relational dynamics with a transcendent being (God) and the second involving religious practices emanating from the participants' spiritual worldviews.

Spirituality as contributing to QoL. The majority of the participants indicated that their spiritual life contributed largely to establishing strong QoL. One of the female participants stated: *‘Every person that doesn’t live for Him with their whole heart or live through Him is unable to enjoy the QoL that only He gives’* [interviews]. The participants’ relationship with God revealed how much they relied on this relationship: *‘It is only by the grace of God that I am able to get through each day’* [interview] and *‘I have to start each day by being still in front of God and reading the word to get my priorities straight. Without Him I easily stray and become upset’* [journal].

Furthermore, participants often referred to their spiritual worldview and to God in making sense of the hard things in life, such as the loss of loved ones and coping with ill health. One participant stated: *‘My life is in His hands and I cannot even add a day to it. If He wants to heal me, He will’* [interview]. Another participant explained in a Mmogo-method[®] discussion that her husband has advanced Alzheimer’s disease and that he has been sick for many years. It was extremely hard for her to accept that he will never get better but she also stated that the only thing that makes her able to accept this is God. She stated that God enables her to go to the frail care unit every day to feed her husband and when she feels that everything is getting too much for her, He gives her new strength. She also testified that God placed her children *‘around’* her to fill the void that she experiences through the loss of her husband. Please see her projection below.



Figure 2. Representation of an individual's perceived contributors to QoL

Spirituality was furthermore found to provide the participants with a social support network since they held Bible study groups, prayer groups as well as church services at and outside of the facility (some participants formed part of church congregations outside of the facility). Participants felt supported by others with the same spiritual foundation and belief system, this being reflected in the following quotation: *'When I have problems I can tell them (the Bible study group), or when others get sick we pray for them and take food to them'*.

Inhibitors of spirituality. Even though spirituality is mostly regarded as an aspect that holds only positive prospects, some participants mentioned that when their spiritual needs were not met, this exercised a negative impact on their overall QoL. Some participants mentioned that they no longer wanted to conform to traditional, rigid and *'empty'* religious tasks and routines. For example, a participant was dissatisfied with her church-going activities: *'I went to the congregation (at the facility) for almost 10 years, and many times I asked myself why I went there because there was such a lifelessness among the people'*. This participant started to attend services at a new congregation and she stated that *'the congregation has become my new spiritual home. I receive the right spiritual food there and the quality of my life has increased so much since I started going there'* [journal].

Relationships

Within the broad domain of relationships, marriage, kinship, close friendships, and co-operation with acquaintances such as the staff members at the care facilities are all associated with the QoL of older people.

Contributing effect of relationships to QoL. Having regular face-to-face contact as well as supportive, loving and quality relationships with family members was stated as being imperative to the study's participants. This emerged in statements such as the following: '*We are blessed to still be able to travel and visit our children and to have them visit us regularly*' [interview]; and '*Loving, in-depth relationships are of the utmost importance for good quality of life*' [focus group]. A participant projected their family vacations with their grandchildren in the picture below [Mmogo-method[®]]. She explained that the small human figures in the projection were her two grandchildren; the larger figures represented her husband and herself. Two scenarios were projected in this case; a seaside vacation as well as a break away to the farm where their children live. It was concluded that close familial relationships in a joyful and comfortable atmosphere contributed to QoL.



Figure 3. A family vacation as contributor to QoL

Close social relationships with others in or outside the facility was also mentioned as contributing to their QoL. Participants referred to people who they knew well and could rely on as being close to them. For example, one participant stated: *'My neighbour and I have lived together here for almost 10 year now. When she goes away I water her plants, and when I am away she feeds Mickey (a parrot)'* [focus group]. Social relationships outside of the facility allowed for interaction in different contexts and gave older people things to look forward to apart from their daily routines: *'We (members of a book club) come together on a weekly basis at one lady's house, and one of the others usually picks me up... it is nice to still be part of this group'* [interview]. When the participant was asked how this group contributed to her QoL she explained: *'We don't only read, we talk about various things... it is nice to have conversations with other friends'*. Relationships with the staff of the facilities were also mentioned as contributors to QoL in that these people provided a helping hand, a shoulder to cry on and an ear to listen: *'The two in this ward (referring to care givers) are very good to us and really help us a lot, especially with the things that are difficult for me like reaching the back of my head and taking things from my cupboard'* [interview]. Another participant stated: *'She (care giver) has worked here a long time and I don't know what I will do without her... each Christmas I send things for her kids at home'* [interview]. From this it is noted that reciprocal care does sometimes exist in these relationships with staff members.

Relational inhibitors. The loss of important relationships through death exercised an inhibiting effect on QoL. A participant in the focus group spoke on behalf of many in mentioning that *'when children live far away it's difficult to come together...many people here don't have cars or drive, and also not for long distances'*. The passing on of spouses, missing children who have died or missing children in general as well as friends who had died or moved to other locations, was said to have a great impact on QoL. For example, a participant shared: *'We were a family of seven children and all my siblings have died, as also*

my husband a few years ago... I still have my daughter which I'm thankful for but you miss all those people who were part of your life' [interview]. Another stated that *'our neighbours of many years moved closer to their children and shortly after this we (her husband and herself) moved here (to the facility) and we have never seen them since'* [focus group]. The participant stated that they still had contact (telephonically) but that she misses the things they did together. In many instances these losses in relationships led the participants to feel lonely. Loneliness can be described as the deficit between actual and desired level of social engagement. Many participants expressed a need for more contact with close friends or family members. When participants were asked what caused them to be lonely despite being surrounded by peers, responses like *'days can get very long and good conversation is scarce'* and *'people are mostly friendly but you still only have a select few who you can feel close to'* surfaced.

Conflict in relationships inhibited the QoL of older people. Some participants felt excluded and rejected by their families. For example, one participant shared: *'I don't see my son because of what happened after my husband died* (referring to disputes over the husband's will) [interview]. In the focus groups it was stated that *'some people come here because their families can't take care them. They don't want to be here, so they basically sit here and wait to die'*. Participants also mentioned quarrels amongst residents which created a bad atmosphere at the facility that would sometimes linger for a period of time. A participant wrote *'The things that take away my QoL are when so-called friends here (at the facility) gossip behind my back and act as if nothing happened'* [journal]. It was also mentioned that for some it was not that easy to form and establish new friendships in the facilities. For example, a participant mentioned that *'some people sit in their rooms for the whole day, they keep to themselves... they do not engage'* [interview]. When this participant was asked if the activities offered at the facility helped her to make new friends she stated *'yes, people attend*

those things, but not all. A few go for the sake of keeping busy but it's for an hour or two and then you go on'. From such statements it became evident that organised activities offered to older people did not fulfil their need for quality relationships and rather acted as a way to pass time and socialise with others. Furthermore, a common problem seemed to be that residents complained about petty things and sometimes wilfully made trouble, as mentioned in the following quote: *'...she went to the office and complained about my radio... she didn't come to me first'* [interview]. In one of the focus group discussions it was mentioned that when older people themselves misplace their belongings *'they accuse the care workers of taking their belongings but also do not apologise when they find their stuff'*.

Health

The health-related aspects of older people included physical health, physical independence in terms of mobility and the ability to carry out activities of daily living. Furthermore, older people's cognitive abilities also formed part of this domain.

Functional health as contributor. Being in good health provided participants with improved QoL because it gave them a sense of independence in that they were not a burden to others and were free to do what they wanted. For example, a participant mentioned that *'without good health there is no QoL. To still be able to do your things and come and go freely is truly a blessing at my age... my daughter helps only with difficult things such as banking and my cell phone, but I do all the rest by myself'* [interview]. Participants seemed to understand the value of good health in old age: *'They say without money a man can do nothing... but when you get older you realise health is more important than money or any other thing on earth'* [focus group]. Satisfactory physical abilities in terms of bodily strength and mobility as well as sharp cognitive abilities contributed to QoL in a profound way, especially as the participants in these contexts were very aware of and confronted with the

absence of health in fellow residents. One of the interview participants mentioned that *'I'm thankful to still be sharp (referring to cognition) despite my body getting slower'*. Participants furthermore revealed a sense of responsibility towards their own health as revealed through the ability to regulate their health by making certain adjustments. The following journal inscription is illustrative of this: *'I realise that I have to manage my health, I must rest enough, relax and do suitable exercise and look into my eating habits'*.

Declines in health as inhibitors of QoL. The inverse of good health is associated with illness, physical pain, decreased energy levels, prolonged periods of suffering, high medical bills as well as decreasing cognitive abilities evident in the inability to recall details. A 78-year-old woman explained that it was hard for her to accept that she is becoming frail and that her energy levels often fail her. She also mentioned being aware of the fact that she had difficulty recalling things: *'My memory and energy are not what they were before. I try to see these faults or blonde moments as something ordinary in the senior years and many times the names that go away come back to me when I calm down'* [interview]. Another participant expressed a decrease in her physical ability, sharing that *'for some time now I have not been able to walk three times a week like I used to...I miss it'*. Other residents' health problems also impacted on the participants, as seen in the following statements: *'At one point it felt as if everyone around me had cancer. When their children visited they (the children) cried a lot... it is hard to see others having so much pain'* [interview]; *'There are older people here that suffer a lot and many are sick for a long time before they die... they remain in their rooms or in the hospital, which is very expensive'*. At these facilities, residents with ill health are often moved to specific wards or care units to be cared for and these services hold additional financial implications. In one of the focus group discussions it was stated that *'most residents pass on in the winter'*. It would thus seem that many participants associate the colder season with ill health and losses.

Meaningfulness

Participants described meaningfulness in terms of having a purpose in life and feeling needed by others. The participants mentioned that being able to lend assistance to their families (mainly children and grandchildren), frail residents at the facility, less fortunate people, and community projects at their church added meaning to their lives.

Contribution of meaningfulness. Participants stated that having something to live for contributed to older people's QoL. In one of the focus group discussions the participants differentiated between *merely living to pass time* and *living with meaning* to make each day count [focus group]. Participants felt as if their lives had meaning when close individuals needed their help, especially children and grandchildren: *'I sometimes like to help my daughter to drive the kids around or by looking after them. It makes me feel that I am still able to do something that is important to her'* [interview]. Please consider the figure below where a participant projected her QoL in terms of providing care. The objects in this presentation were identified as the participant being the care giver. The baby resembled the youngest of her grandchildren who she cared for. This participant also mentioned assisting with the care of her other grandchildren when they were younger. This participant was a professional nurse up until her retirement and she stated that caring for others continues to be important to her in old age. She shared that she visits the frail care unit from time to time and also goes to see other residents in the facility to help where she can.



Figure 4. Meaningfulness projected through caring for grandchildren

Others also stated that reaching out made them feel that their lives were still important and of value to others. One participant explained: *'I am part of a group of seven (four resided in the facility and three outside) who each donate a little money every month to support a needy family with groceries'* [interview]. Another wrote that *'I want my actions to count for eternity. There are many people here to reach out to who are in need of help'* [journal]. In addition it was concluded that participants themselves needed to regard their involvement in life (and at the facility) as meaningful: *'I don't merely want to be occupied with activities, but to enjoy doing the daily things that are essential and needed'* [interview]. A reference to QoL can also be seen in the following quotation, where a participant emphasises the continuous need for new experiences and challenges: *'New challenges are essential for QoL. One has to try new things never experienced before for the sake of your body and spirit, or just new things in the place of things that you are no longer able to do because of age'* [journal].

Inhibitors of meaningfulness. Focus group discussions shed light on the boredom of many residents in the care facility: *'They sit and stare; they don't make conversation or they stay in their rooms for large parts of the day'*. The participants in one of the focus group discussions concluded that QoL was inhibited by boredom and that the bored residents were

also the ones that complained about a lack of opportunities at the facilities, despite the fact that they keep to themselves and are evasive. Participants in the focus group were of the opinion that bored residents are difficult and complain intentionally to get attention from staff or other residents. When these focus group participants were asked why people don't engage in activities or get hobbies, the responses were: *'Some are too old and frail'*; *'It's easier to do nothing'*; and *'People lose interest in life'*.

Sense of Place

Sense of place in this study refers to the physical structure of the facility as well as other environmental aspects that are important to older people, such as access to nature and privacy, safety and security as well as the ability to afford residing in the facility.

Contributors to sense of place. Sense of place was said to be particularly important in terms of helping participants to feel secure, as in the case of this following participant: *'A great thing about the facility is that we are safe here'* [focus group]. Participants agreed that they felt weary and unable to protect themselves in the wider society. Participants also expressed a need to have access to nature at the care facility, as many of them came from environments where they had ample living space. One of the residential care facilities was situated beside a small river. An interview participant stated that *'being able to look at the water every day and walking under the trees gives quality to my life'*. In the other facilities, the same trends were noted as numerous participants expressed the need *'to be outside from time to time'*, *'walk in the garden'*, *'look at the sunset'*, *'water plants'*, *'do gardening'* and *'hear and feed birds'* [focus group]. From a visual projection it was gathered that because participants often felt limited in terms of the physical living space in a facility, access to nature gave them a sense of freedom. Please consider the figure below:



Figure 5. Access to nature projected as a contributor to sense of place

The elements in this presentation were identified as the participant in a natural environment. When she was asked whether it resembled a specific place, she stated that any tranquil place with many trees and a good view and beautiful landscape was sufficient. She furthermore stated that she felt more connected to God when she spends time outside. She further explained that she always had a dog and that having a pet would give more quality to her life but the facility didn't permit residents to have pets (the facilities allowed birds or caged animals to residents who lived in apartments but not to those who stayed in single rooms).

The physical structure of the facility was also important in terms of not having too many stairs, having a practical layout with easy access to the dining hall, frail care unit as well as the TV room as most of the residents use these facilities on a regular basis. This is seen in one of the statements made by a participant: *'I don't want to move rooms. I am close to the dining hall and the nurse station and close enough to get outside easily'* [interview].

Inhibitors of sense of place. Inhibitors of the participants' ability to feel at home and at ease in their environment were expressed as a loss of privacy as *'anyone knows everyone's business'*, financial constraints *'not all residents have good pensions, it is costly to live here'*

and feeling isolated *‘a lot of older people give up their cars when they come here and it cuts them off from the rest of the world’*.

Autonomy

The need for autonomy was described by participants in terms of their ability to make their own decisions in directing their own lives and choices. Aspects that were mentioned as enhancing factors of participants’ autonomy were control, individuality and self-regulation (emotionally, physically, and financially).

Contributors to autonomy. Many participants appeared to be aware of their own influence on circumstances. According to a male participant *‘quality of life is what you make of it, you decide whether you want it or not’*. When he was asked to elaborate on what he meant, he explained *‘One says goodbye to a lot of things, to a lot of freedom, a lot of people and also to a lot of space, but I believe a person is able to be happy anywhere if they want to be’* [focus group]. Many participants seemed to understand that controlling one’s internal processes constructively allows for adaptation in their environment. Furthermore, it was also found to be important for participants to still make their own decisions and to be regarded as individuals, as seen in the following statement: *‘On movie days, I can choose whether I want to go to the TV room or not... not everybody has the same taste in movies’*. Some participants wilfully choose to assume spectator roles and not to be a part of the organised activities at facilities. Participants’ preferences in terms of clothing, food, personal behaviours, social choices and especially what they spend their money on were things over which they liked to have a sense of control.

Inhibitors of autonomy. In contrast herewith, when the ability to be autonomous was taken away from older people they were prone to become more critical and to have negative attitudes about institutional life and their QoL. When older people felt that they weren’t

treated with respect or when they were being '*treated as children*' [focus group], they felt that their autonomy was taken away from them and they were more prone to have negative mind sets and behavioural traits. They felt that they lose their sense of self-worth when their dignity and individuality is taken away from them.

Discussion

The findings of this study correlate with the work of others in the field who have broadly described the domains of belief systems, health, social relationships, environment, individuality, independence and meaningful existence to be important to older people's QoL (Bond & Corner, 2004; Bowling, 1995; Gabriel & Bowling, 2004; Walker, 2005). This study contributed to the body of knowledge on QoL by further distinguishing between contributors to and inhibitors of QoL domains. The domains of QoL were described as being interconnected and mutually informing, not as loose or separate ideas (evident in the literature at times). The contributors to and inhibitors of QoL were also found not to oppose one another but allowed for a non-idealistic and balanced conception of QoL through revealing aspects that bring older people closer to having a good life as well as other aspects that reduce this potential.

The six domains of QoL (spirituality, relationships, health, meaningfulness, sense of place and autonomy) were discussed in terms of their contributing and inhibiting potential. Spirituality contributed to the QoL of older people because their relationships with God and other people are perceived as supportive and are relied upon as a coping strategy to deal with challenges. Although spirituality is regarded as contributing to the QoL of older people, the formality of the traditions or rituals in which spirituality is practiced seems to inhibit the QoL of some people. A distinction needs to be made between spirituality and religion because spirituality refers to people's relationship with the transcendent, while religion refers more to

the ritualised practices (Marcoen, 2005; Roos, 2013; Sulmasy, 2001). Relationships with people, such as close familial relations, social relations and those of a more professional nature such as that with staff members in the residential care facility, serve a valuable function to promote people's QoL. Similarly, the loss of relationships and conflicted relationships diminish the subjective experience of QoL. The relational inhibitors emerged on an uncontrollable and controllable level. Many older people are confronted with the loss of relationships and they do not have control over the fact that the relationships are no longer available. However, dealing with the grief associated with the losses or with the conflict in the relationship can assist older people to enhance their QoL by forming new relationships (Liu & Guo, 2007; McInnis & White, 2001; Roos & Du Toit, 2013).

Studies of QoL in the advanced years have found that a person's health translates to maintained abilities and not necessarily to freedom from illness or impairment (Bowling, 1996; Netuveli, Hildon, Montgomery, Wiggins, & Blane, 2005). The health of older people can easily sketch a bleak picture of QoL since most people over the age of 65 years have some form of chronic illness (Aldwin & Gilmer, 2004; Buckley, 2008). Predictably, QoL associated with health includes physical and cognitive abilities to function optimally and to maintain independence, while low QoL is associated with declining physical and cognitive abilities. For this reason the awareness of older people that they can regulate certain aspects to promote their health is important. It is necessary for older people to be autonomous and to have the perception that they are making decisions and choices and directing their own lives (Lidz, Fischer, & Arnold, 1992; Kane & Kane, 2001). Despite declining abilities, people can make adjustments to sustain their abilities longer if they make healthy choices, have the right mind set and if they have an environment which promotes their natural inclination to be independent and autonomous.

QoL was found to be associated with living a meaningful life which, in the context of the present study, is expressed as having a purpose in life, having feelings of worth to other people, engaging in meaningful activities and being able to deal with challenges. What is meaningful to people will differ according to the physical status and the unique individual traits of people (Kivnick, 1993). Often risks are removed to “protect” older people in organised care facilities, but it has been found that to have QoL is to engage in life which includes having to deal with risks and challenges (Kane & Kane, 2005). Understandably, meaning is threatened by boredom and a lack of stimulation and new challenges.

People always function in a particular environment; referred to in this study as a sense of place. A sense of place is a complex term which refers to a variety of aspects that exercise an influence on an individual’s relation to their environment (Puren, Drewes, & Roos, 2008). People in residential care facilities experienced that their QoL is promoted if they have access to nature. They also want privacy, which can easily be compromised if many people share the same space. Needless to say the physical environment should also be safe (Parker et al., 2004). If people perceive that they do not have privacy and that they are excluded from a broader social environment, their QoL is inhibited. Furthermore, it was also found that the possibility of not being able to afford living standards in the facility threatened their QoL.

Recommendations and Limitations

QoL in residential care facilities is a complex issue that should essentially be regarded as an individual state. Psychosocial intervention aimed at the promotion of QoL requires insight into the lives of the individuals concerned. It is recommended that emphasis should be placed on maintaining and enhancing the contributing aspects of QoL. Residential care facilities should reconsider care strategies which will allow older people to remain independent for as long as possible. Residents should also be allowed to make decisions on

life aspects according to their abilities. A healthy lifestyle in terms of nutrition and exercise ought to be endorsed. Furthermore it is recommended that opportunities should be provided for residents to engage in meaningful activities.

The activities that are offered in facilities should not serve the purpose of merely keeping older people busy. It should be borne in mind that quality relationships are not fostered through activities but in meaningful engagement between various parties. This research endorses environments that are homelike, safe and private, and not like the conditions found in hospitals. More natural environments are recommended as the research found that access to nature gave participants a sense of freedom. Tending to the spiritual needs of residents can potentially enable them to cope better with adversities. Spirituality also emerged as a factor that seemed to bring people closer together, in or outside of the facility. The social and relational needs of residents could potentially be enhanced through the transformational potential of spirituality. Relationships were found to be a crucial element through which older people experienced QoL.

Skewed power relationships between residents and care givers as well as conflict between residents calls for attention. The significance to older people of quality relationships in these settings is not fully understood at this point. Future studies are required to seek ways in which qualitative relationships can be enhanced and maintained throughout the lifespan. The results of this study were limited to the accounts of the older persons that participated and should not be generalised to older people elsewhere.

Conclusion

Person-orientated QoL studies in residential care facilities are important since the proportion of older white South Africans who will prospectively reside in residential care facilities is expected to increase, especially with the influx of the baby boomer generation. In

this study, the construct of QoL comprised six domains, namely spirituality, relationships, health, meaningfulness, sense of place and autonomy. By identifying the contributors to and the inhibitors of the QoL of older people, intervention programmes can be designed and practices could be adjusted to promote their QoL. It must be kept in mind that QoL is a subjective experience in that it is always embedded in relationships and the broader environment.

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CHAPTER 4

ARTICLE 3

A CONCEPTUAL MODEL OF QUALITY OF LIFE FOR OLDER PEOPLE IN RESIDENTIAL CARE FACILITIES IN SOUTH AFRICA

A Conceptual Model of Quality of Life for Older People in Residential Care Facilities in South Africa

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Abstract

This study explored older people's construction of quality of life (QoL) whilst living in a residential care facility. Six domains related to QoL were derived from a larger qualitative inquiry that employed multiple data collection techniques (interviews, focus groups, journals and the Mmogo-method[®]) with 54 older people living in residential care facilities in South Africa. The findings of the study were presented to 19 older people who participated in the initial stages of data collection and availed themselves for further involvement in the research. Based on Interactive Qualitative Analysis (IQA) procedures, participants were requested to judge cause and effect relationships between the six domains, namely: spirituality, health, meaningfulness, sense of place, autonomy and relationships. The IQA approach was utilised to extract a conceptual model which described older people's QoL. QoL was presented as a complex system comprising two feedback systems, i.e. (i) the physical ability to live meaningfully facilitated through spirituality; and (ii) intra-personal meaningfulness in the environmental context. The causal influences between the two feedback systems seemed to have an effect on the relational aspects of older people's lives. Theoretical and methodological contributions emerged from this study. The article is concluded with recommendations and practical implications of the conceptual model.

Keywords: Quality of life; older people, Interactive Qualitative Analysis; residential care facilities; general systems theory; conceptual model

Introduction

Population ageing refers in simplistic terms to the process by which people that are 60 years or older become a proportionally larger component of the total population (Joubert & Bradshaw, 2006). Population ageing has become a well-publicised phenomenon and public concern in the more developed nations. Successful ageing of older people has been established as a key objective for policies related to older people by the Madrid International Plan of Action on Ageing (2002), especially for those in developing countries, since population ageing takes place much more rapidly there than in developed countries and on relatively larger population bases (World Population Ageing, 2009). Successful ageing, wellness, optimal ageing and well-being have also received ample gerontological research attention from multiple disciplinary orientations. These constructs are very relevant to the field of positive psychology, where these constructs are referred to as the subjective social and cultural states that characterise a good life, a life of quality or quality of life (QoL) (Carr, 2004; Linley & Joseph, 2012).

The evaluation and understanding of QoL in people's extended years have become increasingly important in the health, psychological and social sciences as well as in the health and social agendas of many countries (Blane, Netuveli, & Montgomery, 2008; Hyde, Wiggins, Higgs & Blane, 2003; Peel, Bartlett, & McClure, 2004). Initially, psychological gerontology focused extensively on how people adapt to the stressors and constraints of ageing via labels such as life satisfaction, morale and mental health (Baltes & Baltes, 1990; Hyde et al., 2003). High levels of these dimensions were taken as an indication of strong adaptability and successful ageing (Daatland, 2005). However, these studies did not explore or attempt to answer the question of what a good life is. Despite more recent research efforts in the field of QoL, the territory seems to come with complications as there is little agreement on where to focus research attention. Various approaches are found in the academic literature,

including aspirations towards defining QoL, domain-specific research as well as quantifying QoL by trying to express it in numerical terms to measure and describe it (Brown, Bowling, & Flynn, 2004; Dijkers, 2007; Franks, 1996; Haywood, Garratt, Schmidt, Mackintosh, & Fitzpatrick, 2004; Kane, 2001; Lassey & Lassey, 2001; Walker, 2005).

From a narrative literature review by Halvorsrud and Kalfoss (2007), where they investigated empirical studies that aimed to conceptualise and measure QoL among older people from 1994 to 2006, it was revealed that many studies lacked a conceptual and theoretical framework and more than half of the over 400 studies under review did not report any methodological considerations related to older people. Most of the research on QoL tends to lack sensitivity to the subtleness or complexity inherent in human behaviours (Dijkers, 2005). Psychological research on the QoL of older people likewise has emphasised numerous key problems including methodological shortcomings, a lack of an agreed-upon theoretical basis as well as the inability to define or state what is meant by QoL as utilised in the particular research context (Bowling, 1995; Gabriel & Bowling, 2004; Lawton, 1991; Peace, 1993).

For the purpose of this study, the definition of QoL proposed by the World Health Organization Quality of Life group (WHOQOL, 1993) will be used, where the construct is defined as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. This definition has been regarded as a more refined definition by some as it is inclusive of the multi-dimensional nature of QoL (Gilhooly, Gilhooly, & Bowling, 2005). There seems to be some sort of consensus among researchers that the QoL of older people includes physical, emotional and social domains (Brown et al., 2004; Haywood et al., 2004). The conceptualisation of QoL of older people in residential care facilities warrants further investigation. QoL has become a standard of measuring the quality of institutional care or

assisted living facilities for older people (Peace, 1993; Cotter, Salvage, Meyer, & Bridges, 1998; Kane, 2001). According to Ball et al. (2000), assisted living facilities have become increasingly popular long-term residential options for older people as they provide housing, food services, assistance and care for frail older people, as well as the provision of other personal services such as cosmetic services, access to gymnasias, and visits to the facility by doctors.

Research studies have tended to focus on aspects such as the functionality of the facility, the degree of trained and competent staff and the quality of service provision (Kelly-Gillespie, 2009). This is also reflected in the regulatory systems that are put in place (in some facilities) by governments and the management structures of the facilities themselves, although gloomy reports on residents' QoL are found in the literature despite these measures (Kane, 2003; Kane & Kane, 2005; Joseph, 2006; Vetter, 1999). Arguably, legislation on QoL and the management of facilities is more concerned with the objective dimensions of older people's QoL (physical health and living environment). Such approaches tend to drive the conceptualisation of QoL in residential facilities closer to care models for nursing homes or hospitals and away from the kinds of settings that older people would opt for (Kane & Kane, 2001).

In South Africa the same objective trend towards evaluating facilities is evident since governmental audits of residential care facilities have ceased to take into account the subjective dimensions of residents' QoL (Department of Social Development, 2008; 2010). In South Africa predominantly white older people reside in these facilities; this being ascribed to the fact that almost 79% of all facilities are situated in metropolitan and urban areas even though the majority of older people as a proportion of the total population still reside in rural and regional areas (Department of Social Development, 2010). The focus of governmental audits is on basic service delivery, the management capacity in homes, staff

capacity, sustainability and funding, integration of various ethnic groups, multiple uses of facilities, medical services and community outreach programmes (Department of Social Development, 2010). Although these components of residential life do indeed inform QoL, this approach is firstly inconsistent with the varied nature of objective *and* subjective dimensions of QoL that together account for a more optimal experience of life in the residential care facility. Secondly, at the current rate of population ageing in South Africa and the expected influx of older people to such facilities, it is doubted whether the socio-economic and structural modifications of facilities will occur at a fast enough rate to provide optimal satisfaction of the objective dimensions of QoL for the many older South Africans who will turn to these facilities within the next two decades (Joubert & Bradshaw, 2006). Based on the demographic indicators of South Africa's most recent census, ageing trends are most pronounced among white older people (Stats SA, 2011). For this race group more than double the proportion is comprised of older persons (60+ years) compared to Indian/Asians, Africans and coloureds.

Research concerned with the QoL of older people in South Africa is scarce. QoL is often expressed in terms of the socio-economic well-being of people measured in terms of household income and per capita income (Kiyak & Hooyman, 1994; Kironji, 2007). Sources which focus on the psychological well-being of older people and more subjective experiences of QoL are also scarce (Møller, 1998; Møller, 1999; Møller, 2000; Møller, 2007). Ferreira, Keikelame and Mosaval (2001) researched the QoL of older people in terms of health and HIV by comparing studies in various South African communities. Valuable work by Marais and Eigelaar-Meets (Department of Social Development, 2007) has also shed light on the well-being of community dwelling older people in the Western Cape, whereas the work of other authors investigating diverse social phenomena in the context of residential care facilities has provided a baseline for further inquiry (Roos & Du Toit, 2013; Roos & Malan,

2012; Van der Walt, 2011). As a result of the shortfall of QoL literature and research, Van Biljon and Roos have explored the construction of older people's QoL in these settings (2013a; 2013b).

The work of Van Biljon and Roos (2013a; 2013b) takes the historical context of older South Africans into account and provides certain methodological considerations for the study of older people's QoL by suggesting that researchers should not only explore the positive aspects of QoL. This suggestion was made on the basis of the finding in their research that older people are notorious for positivity bias when reflecting on the more subjective issues in their lives (Fernandes, Ross, Wiegand, & Sheyer, 2008). A more nuanced understanding of the nature of older people's QoL in residential care facilities was obtained from the research of Van Biljon and Roos (2013a). These authors found that older participants considered their belief system to be a crucial component of their QoL and that their spiritual worldviews informed their QoL. Furthermore, their ability to regulate their health, behaviour, finances and social interactions further informed the nature of their QoL. The nature of QoL was also described as transitional in that the findings revealed that the domains of QoL deemed to be important by the residents tended to change over time. It was also found that the divergent perspectives on QoL between the genders in earlier life seemed to converge in old age. Six domains concerned with the QoL of older people in these facilities were derived from the work of Van Biljon and Roos (2013a; 2013b). The contributors to and inhibitors of each domain were also explored. These domains were established as spirituality, health, meaningfulness, sense of place, autonomy and relationships.

The findings of Van Biljon and Roos (2013a; 2013b) were supported by those of other authors. Brown et al. (2004) concluded that older people consistently nominated domains such as relationships with family and others, independence and autonomy, finances, health, spirituality, and institutional care as important aspects of QoL. However, a multitude of other

QoL domains have been reported in the literature, including cultural factors, health status characteristics, physical environment, social environment, socio-economic factors, personality factors, personal autonomy factors, access to nature, mobility, subjective well-being, comfort, security, relationships, community, enjoyment, intimacy, meaningful activity, functional capacity, cognitive ability, dignity, privacy, individuality, spiritual well-being, sense of purpose, satisfaction with life, emotional well-being and financial well-being (by no means an exhaustive list) (Bowling & Gabriel, 2004; Cummins, 1996; Farquhar, 1995; Hughes, 1990; Kane, 2001). The overlapping and diversified nature of QoL domains is common and the emphasis of certain domains over others is often largely a matter of personal or group preference (George & Bearon, 1980). For this reason the opinion of Higgs et al. (2005) was valued in their suggestion that QoL should be specified in order to be researchable.

The purpose of the current study was to elaborate on the work of Van Biljon and Roos (2013a; 2013b) by exploring the causal relationships between the specific domains that were distinguished in their research. An understanding of the underlying system dynamics of QoL in care facilities will address the gap in the literature with regards to the interactive relationship of influences between QoL domains (Bond, 1999; Raphael et al., 1997). The conceptualisation of older people's QoL can be viewed more holistically from the perspective of general systems theory (Kelly-Gillespie, 2009). General systems theory emphasises the importance of the interactions between people and various systems, or components of the systems (Von Bertalanffy, 1967; Krippner, James, Engelman, & Granger, 1985). When QoL is explored from a systems perspective, the interrelationships between objective and subjective domains of QoL are highlighted as both have an impact on human behaviour, life circumstances, and quality of life (Bowling et al., 2003; Kelly-Gillespie, 2012). In addition, general systems theory highlights the changes that develop within systems over time.

Aim of the Study

The research question in this study was formulated as follows: How do older people conceptualise their QoL in residential care facilities in terms of cause and effect relations between domains of QoL, based on the six domains deriving from the work of Van Biljon and Roos (2013b)? The aim of this study was to obtain a conceptual model of QoL that is reflective of the system dynamics of how older people construct their QoL in residential care facilities. Such a model will yield theoretical insight into the interrelationships between various domains of QoL. Influential domains as well as those receptive and responsive to these influences will be reported on.

Methodology

Interactive Qualitative Analysis (IQA) is a unique systems approach to qualitative research with the ability to unfold how a particular group of participants' inherent understanding of a phenomenon is structured in terms of perceived cause and effect relationships. IQA is based on a meticulous method for extracting models, as theories of ontology and epistemology are integrated with systems theory to create a clear set of rules according to which studies can be conducted and documented (Northcutt & McCoy, 2004). The ontological position of IQA is consistent with a postmodern critical paradigm and acknowledges the power relations between the researcher and the participants; the participants and not the researcher are regarded as authorities on the dimensions of QoL under investigation (Northcutt & McCoy, 2004). The IQA researcher aims to uncover the workings and relationships of social systems with the analytical assistance of the research participants.

The epistemological base is social constructivist as it recognises that people know their world through the social construction of meaning. Both deduction and induction are

considered necessary to the investigation of meaning and therefore participants are asked to induce meaning and then to define, refine and investigate the relationship of influences among the categories. IQA is supportive of studies that wish to examine how phenomena are socially constructed in order to develop a theory that demonstrates a systemic understanding thereof (Northcutt & McCoy, 2004). The principles of IQA furthermore support constructs of rigour such as credibility, transferability, and dependability as well as the concepts of validity and reliability through a set of accountable and systematic procedures. Due to collaboration between the researcher and participants, the influence of researcher bias is prohibited as the participant has authority over the results of an IQA study. Participants have the opportunity to analyse data which they themselves brought forth. This method was endorsed as it is protective of the minority voices and perspectives of older people in residential care facilities (Human-Vogel & Van Petegem, 2008).

IQA is based on the principles of general systems theory (Von Bertalanffy, 1967; Krippner et al., 1985). The key mechanisms of general systems theory are elements and relationships. Elements and relationships translate to categories of meaning (Northcutt & McCoy, 2004). Furthermore, relational dynamics reveal the nature of the unity represented by the system and shows the intra-systemic inferences (logical effects of changes of state of some elements on others).

Research Context and Participants

The research was conducted at three, non-governmental, independent residential care facilities in South Africa. White older people prefer institutional living and older people of other race groups did not reside in the residential care facilities that formed part of this research. These facilities offer independent living, assisted living and frail care living arrangements and can be described as economically stable facilities with a fair rating in terms

of the general structure, appearance and functionality of the facility (as opposed to either the excellent or poor ratings provided by the Department of Social Development (2010). The motivation for using more than one site was to obtain data from older people residing in multiple contexts to cover an array of aspects that could influence QoL (Mouton, 2009).

Altogether 19 older people availed themselves to participate in the IQA process. All were Afrikaans-speaking; their ages varying between 62 and 95 years at the time of the study (male, n=2 ; female, n= 17). Gender effects (i.e. deriving from the male minority) were not deemed problematic as Bowling et al. (2003) found that the lay views of men and women pertaining to QoL seem to converge at the age of 60. Participants who were involved in previous rounds of data collection for the larger QoL study (Van Biljon & Roos, 2013a; 2013b) were approached to participate in the analytic process. Nineteen (19) participants from the three facilities were respectively willing to participate (n=6; n=5; n=8). Since IQA is described as an analytic tool for qualitative methodology, sample size was not a cause for concern. None of the participants in this study made use of the frail care facilities; they either resided in small apartments on the premises (implying they were still largely independent) or in single bedrooms with an ensuite bathroom (implying that assistance was needed with certain activities of daily living such as domestic help with cleaning and preparing meals). Most participants mentioned that they had contact with their families although some participants' children did not live in close proximity and others' children lived abroad. Participants were approached by means of a working alliance with the management structures of the residential care facilities as was the case in previous rounds of data collection. All participants were able to communicate congruently and seemed to understand the purpose and procedures of the research without any difficulty.

Ethics

Permission was obtained from the Ethics Committee of the North-West University, Potchefstroom. This research project obtained ethical permission under a larger project titled: *An exploration of enabling contexts* (O5K14). The ethical requirements stipulated by the Health Professions Council of South Africa (HPCSA, 2008) were also adhered to. Permission was also obtained from the managers of the residential care facilities to conduct the IQA method. The older people who participated in this study gave written informed consent and were fully aware of the voluntary nature of their participation and of the time that would be taken to conduct the IQA process. Similar to the initial rounds of data collection, participants were reassured that they could withdraw from the study at any time and were not obliged to participate in the research.

Procedure

The IQA research flow can be considered as illustrated in Figure 1:

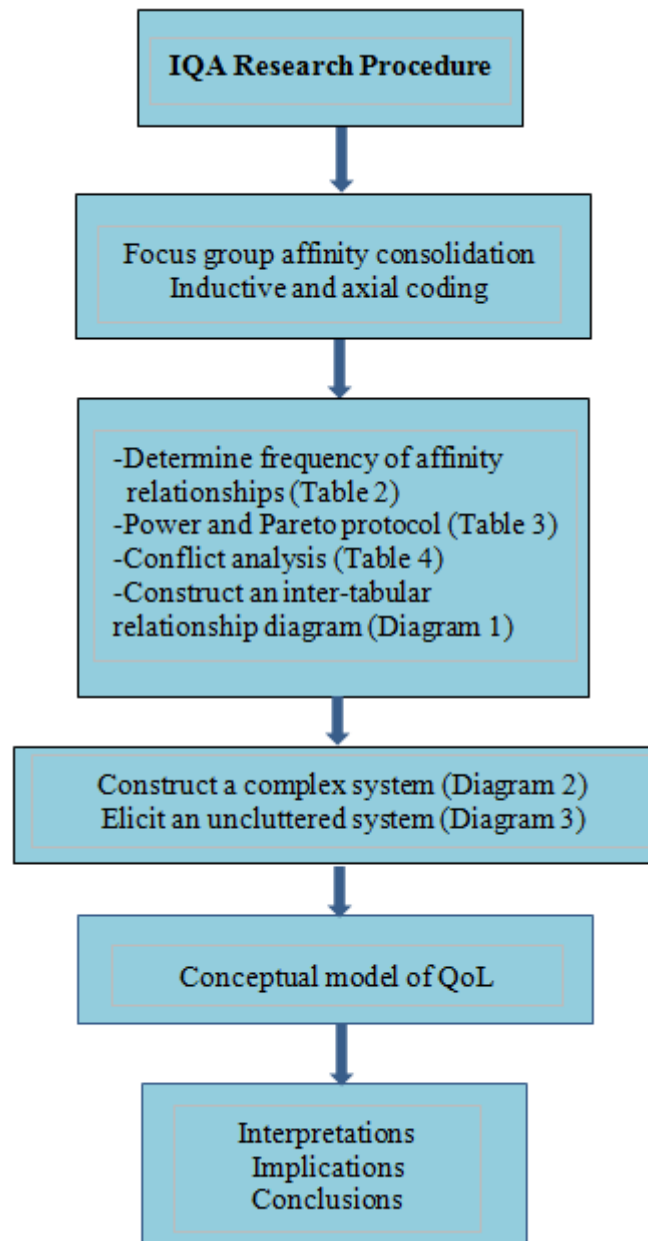


Figure 1. IQA research process adopted from Northcutt and McCoy (2004)

Throughout this research process participants were actively involved in generating data as well as analysing it. The IQA method allowed for the most prominent QoL domains of older people in residential care facilities to emerge. The findings of Van Biljon and Roos

(2013a; 2013b) were discussed with the participants. Six domains were elicited from a global pool of qualitative data gathered by means of various techniques including in-depth interviews, focus groups, journals and a projective technique known as the Mmogo-mthod[®]. Henceforth the domains of QoL will be referred to as QoL affinities, as suggested by IQA protocol (Northcutt & McCoy, 2004). Each of the six affinities was discussed with participants in a focus group setting at the three facilities. Participants were given instructions to rectify or consolidate the findings up to a point where the entire group reached consensus about the meaning of a specific affinity, an activity known as inductive coding (Northcutt & McCoy, 2004). The QoL affinities were confirmed as spirituality, health, meaningfulness, autonomy, sense of place and relationships. Axial codes (the range of meanings of each affinity, as suggested by the participants) were added to the affinities in the axial code table (see Table 1).

Table 1

Axial code table

Affinities	Axial codes
Spirituality	<ul style="list-style-type: none"> - The importance of having a personal relationship with God. - Relying on God for support or to provide help. - Being engaged with spiritual activities. - Having a spiritual community which offers social support.
Relationships	<ul style="list-style-type: none"> - Quality relationships with familial individuals and close friends outside of the facility. - Quality relationships with friends, acquaintances and staff in the facility. - Absent relations and loss of relationships. - Relational conflict.
Sense of place	<ul style="list-style-type: none"> - The importance of nature. - Privacy and space. - Safety and security. - Financial means to afford living standards of the facility. - The opportunity and availability of activities at the facility (social and physical activities, hobbies).

Meaningfulness	<ul style="list-style-type: none"> - Experience a sense of worth by still meaning something to others. - Live life purposefully and avoid just keeping busy. - The significance of what 'meaningful' is changes with age. Things that previously gave meaning like a career, socio-economic position and the impressions of others matter less.
Health	<ul style="list-style-type: none"> - Satisfactory age-related physical and cognitive abilities. - Independence. - Self-regulation and taking responsibility for health (controlling diet, being active). - Cognitive decline, the loss of sensory functions, illness, disease and pain.
Autonomy	<ul style="list-style-type: none"> - Having individual qualities. - Having the ability to make choices. - Inherent behavioural aspects towards people or life in general. - Stereotyping makes all older people uniform and childlike. - Being content in the current life stage.

Participants analysed the nature of the relationship between each of the affinities displayed in Table 1, according to the guidelines provided to them by the researchers. For any two affinities (A and B), participants had the option to choose between three possible relationships, either $A \rightarrow B$ or $B \rightarrow A$ or no relationship existed (i.e. $A \nleftrightarrow B$). For example, participants were instructed to determine whether the affinity 'Health' influences the affinity 'Spirituality' or if the affinity 'Spirituality' influences 'Health', or if there was no relationship between these two affinities. Thus, they had to choose between spirituality \rightarrow health, spirituality \leftarrow health, or spirituality \nleftrightarrow health. Each affinity was related to all other affinities, implying that 30 affinity pairs were subjected to cause and effect relationships. Each participant individually analysed the relationships between the 30 pairs.

All 19 participants' results were combined to produce an integrated affinity relationship table containing all the perceived relationships in the system (Table 2). This table also

displays the frequency of votes that each affinity pair received from the participants. For example, 14 participants were of the opinion that spirituality (1) influences relationships (2).

Table 2

Affinity relationship table

Affinity Pair		Frequency
1.	1 → 2	14
2.	2 ← 6	13
3.	4 ← 6	13
4.	1 → 5	12
5.	1 → 6	12
6.	4 ← 5	12
7.	5 → 6	12
8.	1 ← 4	11
9.	2 ← 4	11
10.	3 ← 5	11
11.	1 → 3	10
12.	2 ← 3	10
13.	2 ← 5	10
14.	3 ← 4	10
15.	1 ← 3	9
16.	3 → 6	9
17.	1 → 4	8
18.	2 → 3	8
19.	1 ← 5	7
20.	1 ← 6	7
21.	2 → 4	7
22.	2 → 5	7
23.	3 ← 6	7
24.	4 → 5	7
25.	2 → 6	6
26.	3 → 4	6
27.	3 → 5	6
28.	4 → 6	6
29.	5 ← 6	6
30.	1 ← 2	5

Affinity name: 1 = Spirituality; 2 = Relationships; 3 = Sense of place; 4 = Meaningfulness; 5 = Health; 6 = Autonomy

The total number of votes for each relationship among all combinations of the affinity pairs was then subjected to a power and Pareto protocol, as described by Northcutt and McCoy (2004). In system terms the Pareto principle states that a minority of the variables in the system will account for the majority of the total variations in the outcome. The Pareto protocol supports the 80/20 principle which supposes that 20% of the votes will cause the

greatest variation (Human-Vogel & Van Petegem, 2008). The ultimate criterion for the construction of an IQA model proposed by Northcutt and McCoy (2004) is one of parsimony, i.e. to use the minimum number of relationships that is most representative of the entire sample's understanding of the phenomenon. IQA uses the Pareto rule to achieve consensus and analytically create a statistical group composite (see Table 3).

Table 3

Power and Pareto protocol for six affinities of QoL

Construct pair	Affinity pair	Frequency sorted (descending)	CF (Cumulative frequency)	CPR (Cumulative percent relation)	CPF (Cumulative percent frequency)	Power
1	1 → 2	14	14	3.333	5.1	1.8
2	2 ← 6	13	27	6.667	9.9	3.3
3	4 ← 6	13	40	10.000	14.7	4.7
4	1 → 5	12	52	13.333	19.1	5.8
5	1 → 6	12	64	16.667	23.5	6.9
6	4 ← 5	12	76	20.000	27.9	7.9
7	5 → 6	12	88	23.333	32.4	9.0
8	1 ← 4	11	99	26.667	36.4	9.7
9	2 ← 4	11	110	30.000	40.4	10.4
10	3 ← 5	11	121	33.333	44.5	11.2
11	1 → 3	10	131	36.667	48.2	11.5
12	2 ← 3	10	141	40.000	51.8	11.8
13	2 ← 5	10	151	43.333	55.5	12.2
14	3 ← 4	10	161	46.667	59.2	12.5
15	1 ← 3	9	170	50.000	62.5	12.5
16	3 → 6	9	179	53.333	65.8	12.5
17	1 → 4	8	187	56.667	68.8	12.1
18	2 → 3	8	195	60.000	71.7	11.7
19	1 ← 5	7	202	63.333	74.3	10.9
20	1 ← 6	7	209	66.667	76.8	10.2
21	2 → 4	7	216	70.000	79.4	9.4
22	2 → 5	7	223	73.333	82.0	8.7
23	3 ← 6	7	230	76.667	84.6	7.9
24	4 → 5	7	237	80.000	87.1	7.1
25	2 → 6	6	243	83.333	89.3	6.0
26	3 → 4	6	249	86.667	91.5	4.9
27	3 → 5	6	255	90.000	93.8	3.8
28	4 → 6	6	261	93.333	96.0	2.6

29	5 ← 6	6	267	96.667	98.2	1.5
30	1 ← 2	5	272	100.000	100.0	0.0

Cumulative frequency is the running cumulative total of votes for each construct pair. **Cumulative percent elation** is 100 divided by the total number of cases (100/30). Each relationship represents 3.3333%. **Cumulative percent frequency** is based on the percentage of the number of votes cast divided by cumulative total of frequencies (NFREQ=272). Thus $272/100=2.72$. **Power** is an index of the degree of optimisation of the system and is calculated as the difference between the previous two columns (CPF-CPR= Power).

The power of the system reached a maximum at the 16th relationship and explained 65.8% of the variation in the system. The distribution of votes was not dictated by a power law such as a Pareto distribution. This means that the majority of votes reflecting specific relationships was not concentrated in a small percentage of the sample, but were distributed more evenly among participants, meaning that more relationships had to be selected to gain a representative sample of responses (Human-Vogel, 2006). The Pareto principle supports a value of 80%, meaning that 22 relationships (82% of variance in the system explained) resembled a more defensible choice.

Among these 22 relationships, votes in opposing directions were evident for relationships. For example, affinity 1 influenced affinity 5 according to 14 votes (1→5; F=14). However, according to seven votes affinity 1 was also influenced by 5 (1←5; F=7). All conflicting relationships were identified and subjected to conflict analysis. Conflict analysis implies that only the relationship with the highest frequency, receiving the majority of votes (1→5; F=14), are used to construct the inter-tabular relationship diagram (Figure 2). Table 4 presents the conflicts that were identified (the votes for relationships in opposite directions). The (x) is indicative of conflicting relationships. The conflict analysis revealed that the initial 16 relationships would have been sufficient to explain the variance in the system but the additional 6 relationships were also considered for the sake of thoroughness. The relationships marked in red were included in the inter-tabular relationship diagram and the relationships marked in light green were left out in the construction of Figure 2.

Table 4

Relationship conflict table

Construct Pair	Affinity Pair Relationship	Frequency	Conflict	Affinity Pairs for IRD
1	$1 \rightarrow 2$	14		$1 \rightarrow 2$
2	$2 \leftarrow 6$	13		$2 \leftarrow 6$
3	$4 \leftarrow 6$	13		$4 \leftarrow 6$
4	$1 \rightarrow 5$	12	X	$1 \rightarrow 5$
5	$1 \rightarrow 6$	12	X	$1 \rightarrow 6$
6	$4 \leftarrow 5$	12		$4 \leftarrow 5$
7	$5 \rightarrow 6$	12		$5 \rightarrow 6$
8	$1 \leftarrow 4$	11	X	$1 \leftarrow 4$
9	$2 \leftarrow 4$	11	X	$2 \leftarrow 4$
10	$3 \leftarrow 5$	11		$3 \leftarrow 5$
11	$1 \rightarrow 3$	10	X	$1 \rightarrow 3$
12	$2 \leftarrow 3$	10	X	$2 \leftarrow 3$
13	$2 \leftarrow 5$	10	X	$2 \leftarrow 5$
14	$3 \leftarrow 4$	10		$3 \leftarrow 4$
15	$1 \leftarrow 3$	9	X	$3 \rightarrow 6$
16	$3 \rightarrow 6$	9		
17	$1 \rightarrow 4$	8	X	
18	$2 \rightarrow 3$	8	X	
19	$1 \leftarrow 5$	7	X	
20	$1 \leftarrow 6$	7	X	
21	$2 \rightarrow 4$	7	X	
22	$2 \rightarrow 5$	7	X	

The inter-tabular relationship diagram (IRD) displays arrows that show whether each affinity in a pair is a cause or an effect in a relationship (Figure 2). The IRD is created by placing arrows into the table showing the direction of the relationship (based on the relationships marked in red from Table 4). Arrows face only left or up, and each relationship is recorded twice in the IRD. For example, if a relationship was determined between A and B, it might be noted as $A \leftarrow B$ and read as B affects A. Two arrows are placed in the IRD to represent the relationship. Both arrows would point away from B toward A. The double entry of each relationship adds to the accuracy of the process. Any data in the upper triangle will be

a mirror image of the bottom triangle should Figure 2 be folded along the black-box line (see black cells in Figure 2). A mistake that often occurs is the omission of an arrow, which leads to an inaccurate representation of the system (Northcutt & McCoy, 2004). All relationships were recorded in the table in this manner.

1 → 2

2 ← 6

4 ← 6

1 → 5

1 → 6

4 ← 5

5 → 6

1 ← 4

2 ← 4

3 ← 5

1 → 3

2 ← 3

2 ← 5

3 ← 4

3 → 6

	1	2	3	4	5	6	↑ OUT	← IN	Δ
1		↑	↑	←	↑	↑	4	1	3
2	←		←	←	←	←	0	5	-5
3	←	↑		←	←	↑	2	3	-1
4	↑	↑	↑		←	←	3	2	1
5	←	↑	↑	↑		↑	4	1	3
6	←	↑	←	↑	←		2	3	-1

Figure 2. Inter-tabular relationship Figure (IRD)

Once the IRD was completed, Delta (Δ) was determined through the following method: Count the number of ↑ up arrows or *outs*, count the number of ← left arrows or *ins*. Subtract the number of *Ins* from the *Outs* to determine the Δ ($\Delta = Out - In$). Delta (Δ) represents the cause and effect relationship among the affinities and determines an affinity's position in the system. In IQA, a system is represented graphically by positioning the drivers and outcomes of the system in specific topologic locations based on the delta values. The topology of a system refers to the pattern of links among the elements in a system. Please consider the sequential topological positions of drivers and outcomes in the system.



Figure 3. Topological positions of drivers and outcomes in the system

A high positive delta is a primary driver and affects all others (i.e. it has only *out* arrows). A low negative delta is a primary outcome and is influenced by all others (i.e. it has only *in*-coming arrows). Secondary drivers and outcomes represent moderate delta numbers (i.e. they have arrows going *out* and coming *in*). Pivots have a delta of 0 indicating an equal amount of *in* and *out* arrows. Delta values from the IRD (Figure 2) are arranged in descending order in Table 5. The order of the deltas helps to determine in which topological zone the affinity should be placed in the systems influence (SID), which is a graphical presentation of the system:

Table 5

Systems influence diagram assignments

SID Assignments			Δ
1	Spirituality	Secondary driver	3
5	Health	Secondary driver	3
4	Meaningfulness	Secondary driver	1
3	Sense of place	Secondary outcome	-1
6	Autonomy	Secondary outcome	-1
2	Relationships	Primary outcome	-5

This system had no primary driver. Secondary drivers of this system were spirituality, health and meaningfulness (aligned to the left in terms of topological position in the system). The system also did not have a pivot. The secondary outcomes were sense of place and autonomy (aligned from the middle to the right) and the primary outcome, relationships (aligned to the right).

Results

The systems influence diagram (SID) flows from the IRD and is a visual representation of an entire system of influences and the transactions between the various QoL affinities. Within the SID, primary drivers and outcomes are named according to the affinity that it is representative of and arrows (links) are drawn to connect them according to the nature of the relationships in the IRD. It is important to remember that the IRD contains a double entry for each relationship. Only one relationship is needed to draw the SID.

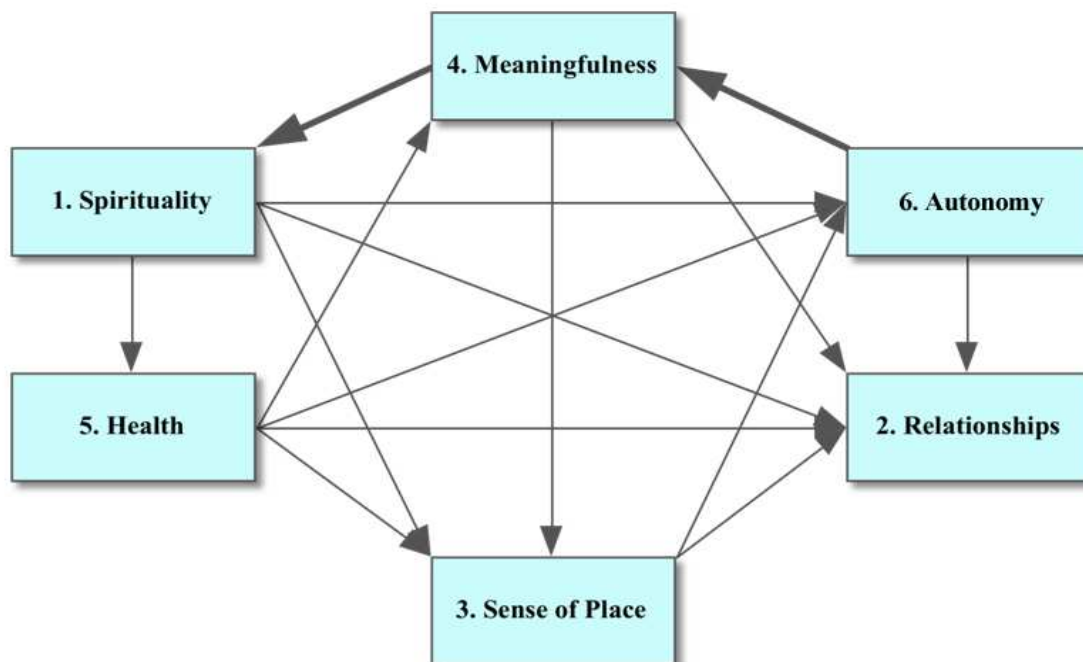


Figure 4. A complex systems diagram

A complex SID, despite being comprehensive can be very difficult to interpret even for a modest number of six affinities such as in the present study. The SID represents a theory; a set of relationships from which hypotheses can be deduced that are consistent with the data and the simplest possible representation (Northcutt & McCoy, 2004). A supplementary and uncluttered SID removes redundant links to construct a simpler model. Redundant links between affinities are removed in the order of delta values. In Figure 4 the secondary drivers (with the highest Δ , i.e. spirituality, health, and meaningfulness) were considered by

investigating their links with other constructs from left to right in terms of the topological order of the system.

In the event of tied/equal delta values (as in the case of affinity 1 and 5 as well as 3 and 6), an examination of the relationship pair in Table 4 will reveal the driver in the relationship. Affinities 1 and 3 were found to be drivers in this system. Redundant links were identified and eliminated by establishing whether a direct link between two constructs could also be explained by an alternative indirect link involving mediating constructs (see Figure 5). If an indirect link could be established, the direct link was removed. The same procedure also applied to the secondary and primary outcome, until all construct pairs and links had been inspected.

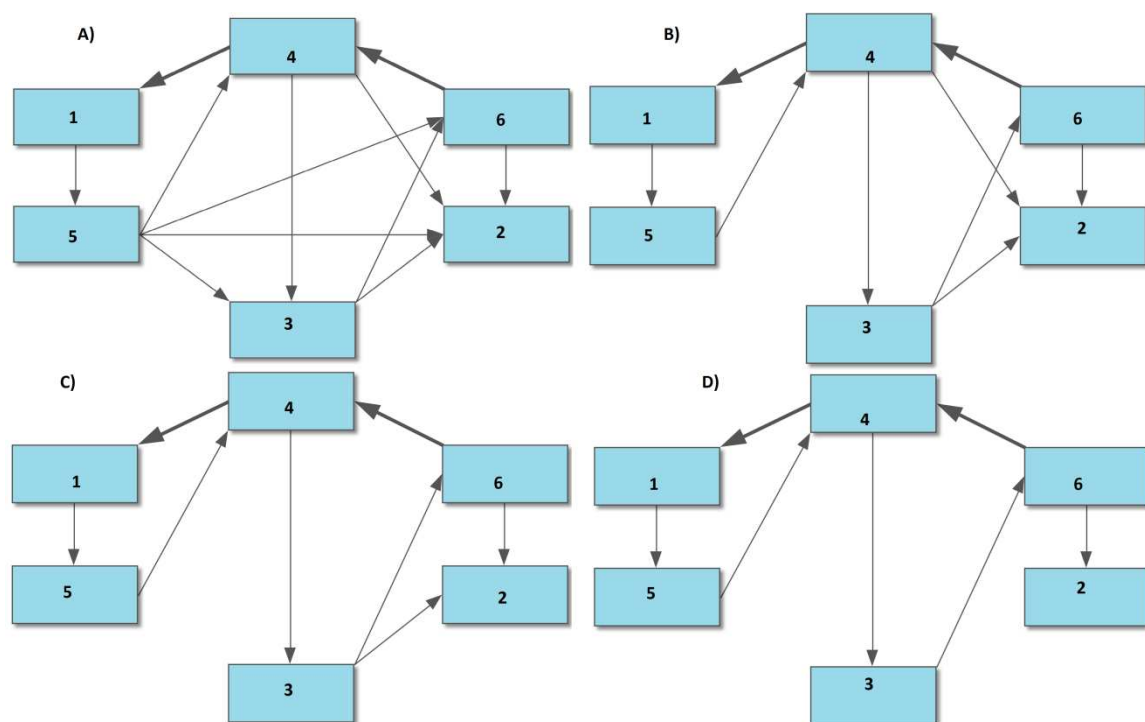


Figure 5. Removal of redundant links

The result is a cleaner representation of the paths of influence between constructs that give the simplest reflection of the most complex relationships between constructs (see Figure 6). The graphic representation of the QoL system provides a visual impression of the system

dynamics and lends itself to analysing how modifications might change the nature of the system.

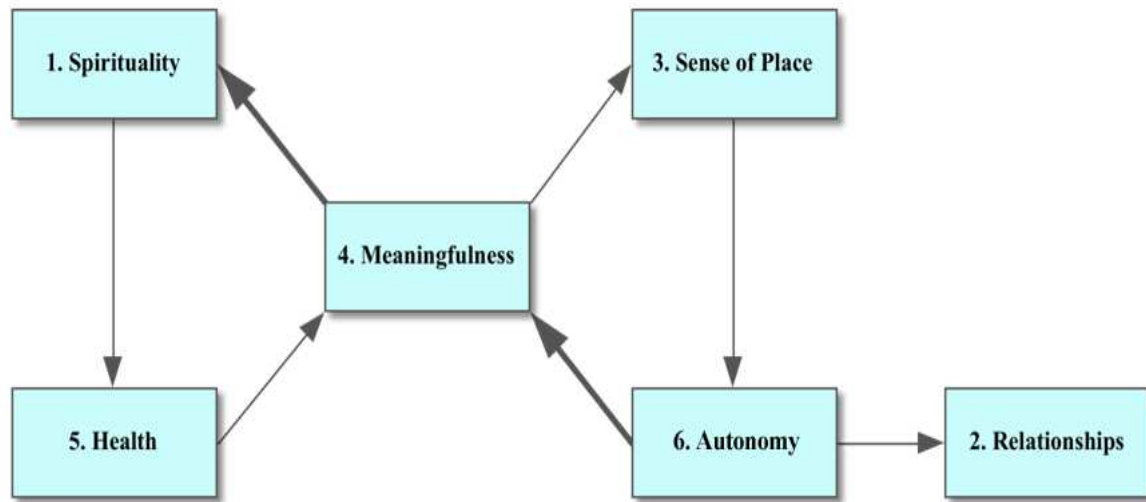


Figure 6. Uncluttered systems influence Figure (SID) of QoL / Conceptual model of QoL.

Discussion

The topological layout of the system will be adhered to in this discussion and components of the system will be discussed systematically. From Figure 6 it can be deduced that a conceptual model of QoL for older people is a complex system consisting of two interlinked feedback systems which influence the relational aspects of older people's QoL. This complies with the work of Albrecht and De Vlieger (1999) who studied the QoL of older people and reported that strong and poor QoL were based on establishing a personal balance between physical, cognitive and spiritual aspects in the self and on establishing and maintaining a harmonious set of relationships within the person's social context and external environment. There are limited published resources utilising an IQA approach, which complicates the usual process of drawing on an existing body of knowledge when describing the data (Human-Vogel & Van Petegem, 2008). The same authors stated that feedback systems are created when there is a path that redirects the influence of a construct to itself,

thus creating a recursive feedback loop. Feedback systems form when a construct has more than two arrows flowing either toward or away from it, creating a feedback point between constructs in the system.

In the QoL system a balanced feedback point developed since one of the constructs (meaningfulness) involved in the recursive feedback loop had two outward and two inward arrows, indicating that its influence is directed via two other constructs in the system and is fed back again into two different constructs (Human-Vogel & Van Petegem, 2008). Balanced feedback points usually create neighbouring feedback systems that interact with each other via one construct. Human-Vogel and Van Petegem (2008) hypothesised that neighbouring and embedded feedback systems will give rise to more cognitive complexity in hypothesising since the system does not have a linear flow. Spirituality, health and meaningfulness were identified as secondary drivers, and autonomy and sense of place as secondary outcomes. The openness of the feedback system allows the effects of each affinity to influence any other affinity. It is therefore impossible to distinguish the true beginning of the system. However, it can be accepted that the system is driven through the interactive relationships between the three secondary drivers of the system.

The first feedback system situated to the left of the model translates to *the physical ability to live a meaningful life facilitated through spirituality*. The three secondary drivers of the system (spirituality, health and meaningfulness) were directly linked, thus comprising a subsystem within the system. The interactional pattern found within this feedback system correlates with the work of Crowther, Parker, Achenbaum, Larimore and Koenig (2002) who found spirituality to be a health-promoting component. Furthermore, Seligman (2002) found that individuals with active spiritual lives often had healthier physical and psychological lifestyles. Similarly, the health status of older individuals influenced the extent to which they could engage in things they perceive as meaningful. According to Lawton, Moss and

Duhamel (1995) continuous meaningful activity for older people is a result of cognitive and physical health. The search for meaningfulness is essentially a personal quest to which spirituality offers some structure (Marcoen, 2005). On a personal level, spirituality refers to the recognition that the inner person is part of a higher order and has a purpose in life larger than the self (Albrecht & De Vlieger, 1999). It can therefore be argued that a person's need for meaningfulness refers them to spirituality as it provides a coherent belief system that allows people to find meaning in life as well as hope for the future, despite adversities in their later years (Seligman, 2002).

The second feedback system situated to the middle of the system translates to the ability to have *personal meaningfulness in the environmental context* of a residential care facility. The influences between meaningfulness, autonomy and sense of place in the second feedback system agrees with the work of Kelly-Gillespie (2009; 2012), who stated that the organisation of QoL in a system is directly linked to the inter- and extra-personal phenomena. Von Faber et al. (2001) emphasised that the inner life of individuals has a significant effect on QoL. Autonomy refers to the intrinsic ability of participants to make their own decisions, to be reckoned as individuals and to be able to regulate and control physical and psychological states (Ball et al., 2000). Regardless of the fact that autonomy was a secondary outcome of this system it influenced the meaningfulness of a person. Arguably, the degree to which the older participants still esteem themselves to have self-worth and dignity, has an impact on their perception of their lives to still be meaningful and have a purpose (Aldwin & Gilmer, 2004).

The participants' perception of meaningfulness in turn influenced their evaluation of a sense of place. In this regard, Albrecht and De Vlieger (1999) stated that higher QoL is experienced when the gap between individual ability (ability to do things that are meaningful) and environmental constraints is reduced. Various environmental aspects such as access to

nature, physical structure of the facility, privacy and space, safety and security, the financial means to afford living standards and availability of activities at the facility were described by participants to give them a sense of place that contributed to their QoL. Participants who were able to live meaningfully (according to their own standards) in an environment that supported their expectations were more satisfied with their QoL (Parker et al., 2004). This resonates with the work of Ball et al. (2000) who found that having something meaningful to do was a key component of residents' QoL.

The older people's sense of place influenced their perceived autonomy in the proposed conceptual model of QoL. Autonomy also refers to the older person's sense of control over their everyday environment and choice of options (Ball et al., 2000; Brown & Ryan, 2004). The same authors found that older people in residential care facilities had fewer options for big choices, implying that control over smaller ones often increases in value (dietary habits, choice of clothing, exercise, etc.). The importance to these residents of independence and autonomy is consistent with other research conducted in assisted residential care facilities (Lidz, Fischer, & Arnold, 1992). Admission to residential care facilities usually means relinquishing one's own routines and habits established over many years, in lieu of the schedule and procedures of the institution (Kane, 2001). According to Kane and Kane (2005) this holds a threat to the autonomy of older people. Care and services provided at the care facility also have the ability to impact on the autonomy of older people. Aldwin and Gilmer (2004) argued that when the tasks and responsibilities of older people are taken away from them or are done for them by staff when they are still able to do these things themselves, they lose their independence and ability to make decisions (despite the comfort and convenience of having the tasks done for them).

The exchange between the two feedback systems exercised an influence on the primary outcome of the QoL system, i.e. relationships. The domain of relationships is thus

most susceptible to be influenced by changes in other of the system's constructs. The relationships of particular concern to the older people in this study were those with family and close friends outside of the facility, as well as relationships with friends, acquaintances and staff in the facility. The essence of quality relationships for social support in later life have been emphasised (Albrecht & DeVlieger, 1999; Aldwin & Gilmer, 2004). In this study relationships with family, particularly children, were vital to the QoL of most participants. Relationships form part of the everyday experiences of all older individuals. The quality and quantity of relationships should not be confused. An older person's ability to engage with many others in an enabling environment does not necessarily satisfy the need for quality relationships. A study by Roos and Malan (2012) revealed that relationships with other residents and staff in a residential care facility were frequently described as unsafe and devoid of care. Their work might explain why participants constantly yearn for interaction with family and close friends that live outside of the facility, as these relationships provide more qualitative relational qualities. The relational outcomes of the participants were directly influenced by their perceived autonomy and indirectly by all other domains. The way in which older people regarded their autonomy (ability to have control, make choices and be regarded as an individual) seemingly exercised an influence on the state of their relationships.

Theoretical Implications of the Research

In the present study quality of life can be viewed as a system embedded in social reality (residential care facility). The flow of QoL in the system was found sometimes to be dysfunctional but it was difficult to pinpoint specific weaknesses in the system because the domains were found to be mutually informing. A dysfunctional QoL system will consequently result in unconstructive relational outcomes in terms of how older people evaluate relationships as well as how they interact in relation to others. Psychosocial intervention with the sole purpose of improving the relational aspects of older people

excludes all other domains that seemingly affect relationships. Domain-specific interventions in this system may turn out to be of little value as some domains are resistant to change, e.g. chronic health states (Blane, Netuveli, & Montgomery, 2008; Hendry & McVittie, 2004) and the physical structure of the facility (Parker et al., 2004). It is suggested that the entire system is strengthened through developing and enhancing domains with transformational ability. The domains that emerged as having the power to reinforce this system were spirituality and autonomy. The domain of spirituality has a cognitive and behavioural transformational ability and has the potential to constructively assist older people with emotional regulation, health aspects, and also to deal with adversities (Seligman, 2002; Roos, 2013). Furthermore, autonomy also emerged as having the potential to give older people a sense of self-esteem and purpose which will reinforce their ability to live meaningful lives.

Contributions of the study

A qualitative approach to the development of a theoretical view of QoL which is person-centred, causal and multidimensional may have significant implications in terms of understanding how older people themselves merit and link the domains of QoL in their specific context. Upon an investigation of international and local literature no other studies were found to make use of Interactive Qualitative Analysis (IQA) with the aim of contributing to a conceptualisation of QoL. This study has set out to enhance the methodological rigour in QoL studies by means of actively engaging older people in the conceptualisation process. This study contributed to the existing body of psychological literature in South Africa concerned with QoL, with a specific focus on a sub-population that is less frequently studied. The research findings bring academic readers, practitioners, policy makers and those who are involved in the field of care and service provision to older people closer to a better understanding of the causal pathways and the influences between the various domains of QoL in older people.

Limitations

The findings of this study revealed a conceptual model of QoL for a specific group of older people in a specific context. The model should be regarded as an approximation of social reality rather than a complete and detailed description and representation thereof. Findings should not be generalised to the broader population of older people or to other contexts although this study made some progress in understanding how people causally relate the domains of QoL in residential care facilities and provided some insight on where to focus intervention, resources and research.

Conclusion

A holistic conceptualisation of QoL goes beyond the mere activities of daily living and health perspectives because it draws attention to the more complete social, psychological and spiritual being. This study shows that a comprehensive conceptual model of QoL, sensitive to the causal influences between QoL domains, could be a promising approach to uncover more about the QoL of older people in residential care facilities. The conceptual model included both objective and subjective dimensions. The model suggests new ways of thinking about QoL in terms of how certain aspects of everyday life, often considered as unrelated, are linked together in a systematic manner. Furthermore, the findings of this study yielded some important insights for care workers and other staff members in terms of the value of spirituality and autonomy for older people in care facilities. The findings also suggest that practitioners and policy makers should be more considerate of the indicators of social and environmental well-being when striving to promote older people's QoL. The results of this study might be of interest to the participants and other residents in care facilities to consider the ways in which the domains of their QoL are related. When older

people are familiarised with the outcomes of this study, they might appreciate that their own actions have the ability to largely inform their experience of QoL.

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CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS AND RECOMMENDATIONS

This study explored the ways in which older people construct their quality of life (QoL) in residential care facilities in South Africa. It is hoped that a better understanding of the QoL preferences of older people and their conceptualisation thereof will inform policy makers, the management structures of facilities, care givers, family members of the residents, and the older people residing in these facilities on how to make decisions to promote their overall QoL and not only to address certain of its dimensions. New knowledge in the area of QoL might direct future research efforts and put current resources in residential care facilities to better use. The study revealed various strengths of older people and shed light on their potential to deal with adversities and challenges that are frequently associated with later life.

Aspects of older people's QoL were studied with a specific focus on three subsequent areas of interest: Firstly, to understand more about the nature of QoL for this specific group of older South Africans in a particular context. The second inquiry explored the contributors to and inhibitors of QoL across various domains in residential care facilities. The aim of this research was to reveal and propose a typology of how QoL can be understood for this particular group of older people in their context. Clarity was sought on how the various domains of QoL influence one another, and thus the third focus was to create a conceptual model of QoL to illustrate the underlying causal influences and exchanges between QoL domains for this group. From the third focus a theoretical proposition arose with the potential to elevate current advances in research concerned with the QoL of older people in long-term institutions.

In the first article the researcher explored the nature of QoL according to the perceptions of the participants. In this study many participants perceived their QoL in a way that is consistent with findings in the gerontological literature, where QoL is described as a

multi-dimensional phenomenon. From a gerontological stance QoL is often viewed in terms of satisfactory associations with health, social interaction, the environment, security, mobility and relationships (Bowling, 2001; Farquhar, 1995). The contribution of this study lies in the more nuanced understanding that has emerged of the dimensions of particular importance to older people in the context of residential care facilities in South Africa. These dimensions are: (i) spirituality, which was found to be connected to the participants' historical context and played a facilitating role in the experience of QoL; (ii) relationships, expressed in terms of reciprocal nurturing relationships with close family, quality friendships in or outside of the facility and relations with staff at the facility; (iii) self-regulation -gave older people a sense of control over their current life state in that many responsibilities are taken away from them in facilities and thus their ability to regulate health, finances and behavioural aspects was found to be connected to their QoL; and (iv) transitionality – i.e. a trend was observed of QoL and its determinants having evolved from the active pursuit of 'doing' things in the past to a state of being content and leading a meaningful existence by 'being' in the present. Furthermore, the study emphasised that the perceptions of QoL are greatly dependent on the functionality of older people and are linked to age.

The focus of the second article evolved from the first. Various aspects were found to contribute to, but also to inhibit the participants' QoL. The second article revealed six domains of QoL as relevant to the group under investigation: (i) *Spirituality* contributed through the participants reporting a supporting relationship with God. This was found to be a coping mechanism and it provided participants with a spiritual support network. Traditional spiritual rituals and practices were found to have an inhibiting effect when the needs for advancement in spiritual growth were not met; (ii) *Relationships* were found to contribute to QoL when participants had close familial and social relationships, as well as positive relationships with the staff. Loss of relationships due to death and conflict in relationships

inhibited QoL; (iii) *Health* aspects such as physical ability, physical independence, and satisfactory cognitive abilities contributed to QoL, whereas reduced physical and cognitive abilities, chronic pain, long-term illness and the awareness of death inhibited it; (iv) *Meaningfulness* was experienced when participants had a purpose in life, felt useful and needed by others, as well as when they had new challenges and things to look forward to. Boredom in care facilities inhibited the capacity of participants to regard their lives as meaningful; (v) A *sense of place* was gained from access to nature, by enjoying privacy, safety and security as well as a fit between the individual and the physical structure of the facility. The loss of privacy, financial constraints and feelings of isolation from broader society created a misfit between the individual and their sense of place; and, lastly, (vi) *Autonomy* was experienced through the maintained ability to have freedom of choice as well as control over certain aspects in life such as what to eat, wear, etc. Self-regulation with regards to the behavioural, physical, and financial aspects of life, as well as perceived individuality, added to autonomy. When participants were treated like children or as a homogenous group, their autonomy was inhibited. Furthermore, negative attitudes, loss of control and dependence on others also had inhibiting effects. The domains of QoL were described as interconnected and mutually informing, not as loose or separate ideas. However, there was still some uncertainty about how the various domains influence one another in the construction of QoL, giving rise to the third focus of the study, i.e. determining the nature of the relations between the various domains.

The third article explored the influences on and relationships between the six above-mentioned QoL domains. Participants judged the cause and effect relationships between domains. They also indicated the direction of the perceived influence of each domain, i.e. whether they exercised an influence *on* or were being influenced *by* the other domains. Interactive Qualitative Analysis (IQA) revealed how the domains of QoL are ordered

systematically. A conceptual model was elicited which proposed older people's construction of QoL as a complex system consisting of two feedback systems (*i.e. [i.] the physical ability to live meaningfully facilitated through spirituality, and [ii.] intra-personal meaningfulness in the environmental context*) which in turn influenced the relational aspects of older people's lives. The influences between the various QoL domains were essentially found to impact on the relational aspects of older people. This study also revealed that spirituality and autonomy both held transformational potential in the system, to enhance the strengths and overall QoL of older people.

CONTRIBUTIONS OF THE STUDY

This study contributes to the body of gerontological literature on QoL in South Africa. Virtually no reported evidence was found, prior to this study, of an exclusive research focus, from a psychological perspective, on the QoL of older white South Africans in residential care facilities. Creating awareness of QoL in care facilities and providing the management structures of these facilities with information, research findings and recommendations is a further contribution of this study. Each of the four facilities that formed the research context of this study received a document with important findings and recommendations (Appendix E).

Traditionally, gerontological research has classified the experiences of older people and expressed it in numerical terms. As a result the majority of resources on QoL are empirical and quantitative in nature, with the informing potential of qualitative research on later life issues only recently starting to draw attention (Victor, 2005). The methodological contributions of this study are found in the qualitative account of a group of older people's experiences in South African residential care facilities, by taking a deeper look into multiple aspects of their lives. Further methodological contributions constitute the implementation of a

rather new method in qualitative research, namely Interactive Qualitative Analysis (IQA) (applied in Chapter 4), the age-conscious manner in which the research was conducted, as well as being alert to positivity bias to which older people are often inclined.

The contribution of the study in terms of psychosocial intervention is expressed in the suggestion that overall QoL can be improved by looking for aspects in older people's lives that have the transformational ability to exert a positive influence on multiple dimensions. Interventions should ideally encompass the promotion of older people's strengths and their potential to grow, with a reduced focus on areas that are resistant to change (e.g. chronic health states, finances, etc.). The findings of this study discourage domain-specific interventions aimed at promoting overall QoL, e.g. employing strategies to improve the relational states of older people but which exclude all the other domains that affect relationships (Blane, Netuveli, & Montgomery, 2008; Hendry & McVittie, 2004).

The contribution of the study on a theoretical level is that the study confirmed the importance of ongoing development throughout the lifespan. Lifespan development theory regards development as biologically and socially constituted, revealing universal developmental traits (similar for all older people) as well as inter-individual variability (for example differences in social class, genetics and historical background) (Baltes & Smith, 1999). The dynamics of lifespan development theory propose a decrease of selection benefits with an increase of age (older people in residential care facilities have fewer options for making significant choices and thus the control that they have over smaller ones often increases in value, e.g. choices involving their diet, clothing, exercise, friendships, etc.). The theory proposes that people are more inclined to have a need for their own culture as they get older (participants often refer back to the way things were when they were younger, i.e. what South Africa was like) although the efficacy of culture seems to decrease with age (loose social ties were evident between residents and some individuals even resented traditional

customs, especially in terms of their spiritual worldviews). This study enhanced knowledge of the adaptive fitness and resilience of older people. Lifespan theory proposes that a condition of loss or constraint has the ability to catalyse positive change in older people. The present study revealed how participants relied on spiritual resources, as well as on inherent strengths such as autonomy, self-regulation, mindfulness and a state of being content to cope with or adapt to adversity.

A further theoretical contribution of the study lies in the suggestion of supplementary theoretical properties to the existing theory, based on the findings of this study. The construction of QoL as revealed in this study agrees largely with the biopsychosocial-spiritual (BPSS) model of Sulmasy (2002). In this author's opinion:

'This biopsychosocial-spiritual model is not a "dualism" in which a "soul" accidentally inhabits a body. Rather, in this model, the biological, the psychological, the social, and the spiritual are only distinct dimensions of the person, and no one aspect can be disaggregated from the whole. Each aspect can be affected differently by a person's history and illness, and each aspect can interact and affect other aspects of the person' (2002, p.27).

It should be kept in mind that the BPSS model does not place strong emphasis on environmental aspects. It is therefore suggested that even more may be understood of QoL if the BPSS model is embedded in an environmental framework.

When relating the findings to theories in positive psychology, the eudemonic approach which guided the study (in terms of finding happiness and the good life through achieving one's full potential) revealed that older people value spiritual advancement, being increasingly mindful of others and by living meaningful lives (Carr, 2004; Seligman, 2002). Meaningfulness was often measured subjectively by the participants in terms of having a well-defined purpose and being needed by others.

In terms of the practical implementation of the theory, the study provided an alternative approach to constructing the QoL of older people by providing a systematic conceptual model informed by general systems theory. General systems theory emphasises the importance of the interactions between people and various systems or components of systems (Von Bertalanffy, 1967; Krippner, James, Engelman, & Granger, 1985). The study contributed by providing new knowledge on how all the domains of QoL interactively influence one another to create a QoL system. Intervention would ideally entail paying attention to the drivers of the system (spirituality, health and meaningfulness) and enhancing the domains with transformational potential (spirituality and autonomy) in order to improve the relational outcomes of older people's lives. General systems theory highlights the change that develops within systems over time, implying that the success of interventions aimed at promoting QoL can easily be determined by evaluating changes in the relational aspects of the individuals concerned.

RECOMMENDATIONS FROM THE STUDY

Recommendations Intended for Policy Makers

Well-being and QoL are generally broadly described in ageing policies, and it is a recommendation of the present study that legislation pertaining to the QoL of older people should be revised. Despite the fact that the Older Persons Act of South Africa (Department of Social Development, 2006) underwent revision in 2008 (Department of Social Development, 2008), no amendments were made pertaining to QoL in residential care facilities. It is recommended that policy makers state more explicitly in the Older Persons Act which specific aspects of QoL they refer to in legislation. Socio-economic welfare and health care

should not be mistaken for the more subjective nature of QoL (as defined by older people themselves).

The White Paper for Social Welfare (1997) has for a long time emphasised the need for community development and in 2000 the Council on Higher Education advocated for students at tertiary level to be exposed to academic service learning. Community projects provide students with the ideal opportunity to engage in academic service learning. Regardless of these important objectives, community projects encompassing academic service learning in residential care facilities have not been implemented according to the findings of a national audit on these care facilities (Department of Social Development, 2010). Psycho-social intervention aimed at promoting QoL requires insight into the lives and context of the individuals concerned. The establishment of a Master's degree in Gerontology at the North-West University has created a platform from which students can carry out supervised practical work in communities of older people. Such community projects implemented by institutions of higher education should receive more efficient legislative backing and financial support from governing structures.

Recommendations Intended for Managers and Care Givers at Residential Care Facilities

Although the study revealed that perceived QoL is a personal state informed by multiple dimensions, residential care facilities do have the potential to directly influence QoL through their management, the physical environment and care plans, and indirectly through their approaches to family and community.

This study endorses the view of Calkins and Bursh (2009), which is steered away from medical models of care in residential care facilities and supports person-centered models of care. Person-centred models of care exert an influence on many aspects in

residential care facilities such as the structure of the management bodies, staff training as well as facility design and layout. A more person-orientated model of care is demonstrated in facilities where older individuals can live comfortably and feel at home as opposed to feeling like they have been institutionalised or are in a hospital. It is recommended that the highest priority should be given to the aspects of residents' privacy, their dignity and their ability to make choices (according to their abilities).

On a practical level the following recommendations are proposed:

- That facilities should create spaces and opportunities for older people to be together with friends and family members in a meaningful and caring manner. The privacy of residents ought to be afforded special attention when people from outside of the facility come to visit.
- Avenues should be explored which enable the older people who are still able to do so to accumulate some revenue either for themselves or for their care facility.

Participants expressed the need for meaningful engagement, as well as being busy with things that have a purpose. These funds can be put towards the upgrading of social facilities such as the TV room or the outside barbeque area, or to sponsor regular social activities.

- Community work is recommended for those who are still able to extend a hand. Various participants reported that they found it meaningful to be engaged in some form of community work.
- Spiritual activities and support groups ought to be initiated in facilities. Most of the participants in this study expressed the need for engagement of this nature. Creative materials such as spiritual DVDs constitute a practical way of engaging a group of people in a spiritual activity, and in this way the burden of keeping the group intact and preparing for these meetings does not rest on one particular individual.

- Attention should be given to negative power relationships between residents and care givers, as well as to conflict between residents. Residents are confronted by these relationships on a daily basis and the research findings show that these conflicts should be resolved and managed in order to improve QoL.
- Care givers should be familiarised with the foci and findings of this study. By being aware of aspects of life that contribute to and inhibit residents' QoL in order to lessen their care giver burden can be reduced. This might also facilitate more positive relationships between personnel and residents.
- Personnel and care workers at residential care facilities are to be encouraged to establish mechanisms and create environments for older people to engage in activities that hold meaning for the residents.
- Engaging residents in activities merely for the sake of keeping them busy does not add quality to their lives. The emphasis should be placed on activities that have meaning to the group or the individual concerned.
- Functional older people (physically and cognitively) seem to be the only beneficiaries of recreational care plans in facilities. Less functional older people were found to be more isolated and in need of social interaction as they were not able to participate in many of the recreational activities offered by the facilities. It is recommended that facilities should be sensitive to the needs and abilities of the more frail residents and should pursue avenues for accommodating and integrating these residents into recreational care plans.

Recommendations for Future Studies

This study shed light on the various strengths of older people that they rely on to develop their potential and overcome adversities. It is recommended that additional qualitative research should be conducted on the strengths of older people in this context in order to nurture the fortigenic potential of older people through psychosocial intervention.

The perspectives on QoL of older people who are frail, cognitively impaired and unable to communicate did not form part of the scope of the current inquiry. Future studies are recommended that seek to develop approaches to observe and assess the QoL of residents who cannot be interviewed by normal means.

Qualitative research is sometimes used as a prelude to statistical enquiry, when the subject matter needs to be more clearly understood before it can be measured (Ritchie, 2009). With the qualitative baseline obtained from this study, it is recommended that future quantitative work in the field be done according to the QoL research protocols suggested by the World Health Organization. The World Health Organization Quality of Life group has 22 international centres which monitor and report on the QoL of older people. South Africa is currently not represented in the data base (Peel, Bartlett, & Marshall; 2007; WHOQOL, 1993). A mixed-methods approach might elicit findings that can be generalised to a broader population and could lead to the promotion of older people's QoL on a larger scale.

LIMITATIONS OF THE STUDY

The findings of this study give an account of the experiences of the participants in their specific context and should not be generalised to other ethnic groups or older people in other contexts. It does, however, pave the way for an in-depth exploration of the QoL of older

people of other ethnicities through the application of the methodological procedure adopted in the current study.

Some might critique the in-depth study of individuals in a micro-environment as an attempt to avoid the wider social context. However, the study of wider social contexts often glosses over the needs of minority groups, whereas the participants of the present study constitute a minority group in South Africa and also constitute the country's largest group of older people (proportional to ethnic group). No frail or cognitively challenged participants were included in the study sample although the majority of facilities care for such individuals. Furthermore, the participants were all from moderate socio-economic backgrounds and thus their financial status did not play a major role in their experience of QoL. These limitations may be justified by the concrete purpose of this study, i.e. to obtain an unbiased perspective of what constructs QoL, avoiding perceptions of QoL being influenced by an individual's health and financial status.

Despite the fact that this qualitative inquiry produced a rich set of data regarding the experiences and perceptions of older people, it also presents with certain disadvantages. It was very difficult and time consuming to turn the generated verbatim discussions into meaningful constructs for use in the data analysis. Many hours of conversation translated into little usable data and took multiple rounds of data collection to effect. Journals and focus groups were regarded as the data collection methods which rendered the study's most usable data.

Even though a sample of 54 is regarded as large in qualitative terms, only 19 participants were involved in an additional round of data validation when Interpretative Qualitative Analysis (IQA) was employed. The size of this smaller sample was jointly due to the limited availability of initial participants at the time of conducting the research procedures

and also due to the novel use of this method in gerontological research settings. A smaller qualitative sample, as suggested by Northcutt and McCoy (2004), was opted for.

FINAL WORDS

I became interested in older people's quality of life as prolonged engagement in the context of residential care facilities revealed a picture to me of the residents leading isolated and uninvolved lifestyles. After almost 4 years of inquiry, I have to a certain extent been able to answer my own personal questions about what can be done to enhance older people's QoL in these facilities. QoL is a personal state, encompassing the body, mind and soul of a person. It is self-informative to a large extent, and is directed and constructed through choices and preferences that accumulate over many years. I have concluded that QoL comprises a multitude of personalised dimensions and it is lived through and expressed in relationships. I envision that the implementation of a more individualised approach to determining what causes residents to appraise their QoL positively or negatively could have widespread benefits, particularly in terms of enhancing relational aspects in multiple, interpersonal contexts (between residents, their families, and those who provide care in the facilities).

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APPENDIX A

Author guidelines of Journal selected for r publication of Article 1.

Journal of Community Psychology

Instructions to authors

The Journal of Community Psychology is a peer-reviewed journal devoted to research, evaluation, assessment, and intervention. Although review articles that deal with human behavior in community settings are occasionally accepted, the journal's primary emphasis is on empirical work that is based in or informs studies to understand community factors that influence, positively and negatively, human development, interaction, and functioning. Articles of interest include descriptions and evaluations of service programs and projects; studies of youth, parenting, and family development; methodological studies for the identification and systematic alteration of risks; and protective factors for emotional and behavioral disorders and for positive development. The journal also publishes the results of projects that inform processes relevant to the design of community-based interventions including strategies for gaining entry, engaging a community in participatory action research, and creating sustainable interventions that remain after project development and empirical work are completed.

Types of manuscripts. Three types of contributions are considered for publication: full-length articles, brief reports of preliminary and pilot studies that have particular heuristic importance and, occasionally, commentaries on conceptual or practical issues related to the discipline's theoretical and methodological foundations. Typically, empirical articles are approximately 30 pages including tables, references, etc; brief reports cannot exceed 12 pages; and commentaries should not, in general, exceed 20 pages. All material submitted will be acknowledged on receipt, assigned a manuscript number, and subject to peer review. Copies of the referees' comments will be forwarded to the author along with the editor's decision. The review process ranges from 12 to 16 weeks, and the journal makes every effort to publish accepted material within 12 months.

Manuscript format. All copy, including references and captions, must be typed double-spaced. An abstract of 150 words or less is required for articles and brief reports.

Style. Authors should follow the stylistic guidelines detailed in the Publication Manual of the American Psychological Association, Fifth Edition, available from the American Psychological Association, Washington, DC. References should also follow APA style.

Figures. Figures should be professionally prepared and submitted in electronic TIFF or EPS format (if possible) along with high-quality printed hard copies. Good glossy black and white photographs are required for halftone reproduction. Figures should appear at the end of the manuscript, after the text.

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journal. Only original papers will be accepted and copyright in published papers will be vested in the publisher. It is the author's responsibility to obtain written permission to reproduce material that has appeared in another publication. Additional information on copyrights and permissions is available at the Journal Author's Site of the Wiley website, <http://www.wiley.com>. Forms can also be downloaded from the journal's For Authors page, see <http://www.interscience.wiley.com>.

Reprints. Reprints of articles may be ordered from the publisher when the corrected proofs are returned. Authors should return the Reprint Order Forms with the proofs. Guidelines for electronic submission

Software and format. Microsoft Word 6.0 is preferred, although manuscripts prepared with any other microcomputer word processor are acceptable. Refrain from complex formatting; the Publisher will style your manuscript according to the Journal design specifications. Do not use desktop publishing software such as Adobe PageMaker or Quark XPress. If you prepared your manuscript with one of these programs, export the text to a word processing format. Please make sure your word processing program's "fast save" feature is turned off. Please do not deliver files that contain hidden text: for example, do not use your word processor's automated features to create footnotes or reference lists.

Illustrations. All print reproduction requires files for full color images to be in a CMYK color space. If possible, ICC or ColorSync profiles of your output device should accompany all digital image submissions.

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Resolution. Journal quality reproduction will require greyscale and color files at resolutions yielding approximately 300 ppi. Bitmapped line art should be submitted at resolutions yielding 600-1200 ppi. These resolutions refer to the output size of the file; if you anticipate that your images will be enlarged or reduced, resolutions should be adjusted accordingly.

File names. Illustration files should be given the 2- or 3-letter extension that identifies the file format used (i.e., .tif, .eps).

APPENDIX B

Author guidelines of journal selected for r publication of Article 2.

Journal of Psychology in Africa

Instructions to authors

The Journal of Psychology in Africa includes original articles, review articles, book reviews, commentaries, special issues, case analyses, reports, special announcements, etc. Contributions should attempt a synthesis of local and universal methodologies and applications. Specifically, manuscripts should: 1) Combine quantitative and qualitative data, 2) Take a systematic qualitative or ethnographic approach, 3) Use an original and creative methodological approach, 4) Address an important but overlooked topic, and 5) Present new theoretical or conceptual ideas. Also, all papers must show an awareness of the cultural context of the research questions asked, the measures used, and the results obtained. Finally the papers should be practical, based on local experience, and applicable to crucial development efforts in key areas of psychology.

Manuscripts. Manuscripts should be submitted in English, French, Portuguese or Spanish. They should be typewritten and double-spaced, with wide margins, using one side of the page only. Manuscripts should be submitted to the Editor-in-Chief, Journal of Psychology in Africa, Professor Elias Mpofu, PhD., CRC, Associate Professor, Faculty of Health Sciences, University of Sydney, Cumberland Campus, East Street, PO Box 170 Lidcombe NSW 1825, Australia, email: e.mpofu@usyd.edu.au. We encourage authors to submit manuscripts via e-mail, in MS Word, but we also require two hard copies of any e-mail submission. Before submitting a manuscript, authors should peruse and consult a recent issue of the Journal of Psychology in Africa for general layout and style. Manuscripts should conform to the publication guidelines of the latest edition of the American Psychological Association (APA) publication manual of instructions for authors.

Manuscript format. All pages must be numbered consecutively, including those containing the references, tables and figures. The typescript of manuscripts should be arranged as follows:

Title. This should be brief, sufficiently informative for retrieval by automatic searching techniques and should contain important keywords (preferable < 10 words).

Author(s) and Address(es) of author(s). The corresponding author must be indicated. The author's respective addresses where the work was done must be indicated. An e-mail address, telephone number and fax number for the corresponding author must be provided.

Abstract: Articles and abstracts must be in English. Submission of abstracts translated in French, Portuguese and /or Spanish is encouraged. For data-based contributions, the abstract should be structured as follows: Objective – the primary purpose of the paper, Method- data source, subjects, design, measurements, data analysis, Results – key findings, and Conclusions- implications, future directions.

For all other contributions (except editorials, letters and book reviews) the abstract must be a concise statement of the content of the paper. Abstracts must not exceed 120 words. It should summarize the information presented in the paper but should not include references.

Referencing. Referencing style should follow APA manual of instructions for authors. Referencing in text: References in running text should be quoted as follows: (Louw & Mkize, 2004), or (Louw 2004), or Louw (2000, 2004a, 2004b), or (Louw & Mkize 2004), or (Mkize, 2003; Louw & Naidoo 2004). All surnames should be cited the first time the reference occurs, e.g. Louw, Mkize, and Naidoo (2004) or (Louw, Mkize, & Naidoo 2004). Subsequent citations should use et al., e.g. Louw et al. (2004) or (Louw et al. 2004). ‘Unpublished observations’ and ‘personal communications’ may be cited in the text, but not in the reference list. Manuscripts accepted but not yet published can be included as references followed by ‘in press’.

Reference list. Full references should be given at the end of the article in alphabetical order, using double spacing. References to journals should include the author’s surnames and initials, the full title of the paper, the full name of the journal, the year of publication, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to books should include the authors’ surnames and initials, the year of publication, the full title of the book, the place of publication, and the publisher’s name. References should be cited as per the examples below (please note the absence of punctuation): Appoh, L. (1995). The effects of parental attitudes, beliefs and values on the nutritional status of their children in two communities in Ghana. Unpublished master’s dissertation, University of Trondheim, Norway Peltzer, K. (2001). Factors at follow-up associated with adherence with directly observed therapy (DOT) for tuberculosis patients in South Africa. *Journal of Psychology in Africa*, 11, 165-185.

Tables. Tables should be either included at the end of the manuscript or as a separate file. Indicate the correct placement by indicating the insertion point in brackets, e.g., <Insert Table 1 approximately here>. Tables should be provided as either tab-delimited text or as MS Word table (One item/cell). Font for tables should be Helvetica text to maintain consistency.

Figures/Graphs/Photos. Figures, graphs and photos should be provided in graphic format (either JPG or TIF) with a separate file for each figure, graph or photo. Indicate the correct placement by indicating the insertion point in brackets, e.g., <Insert Figure 1 approximately here>. Provide the title for the item and any notes that should appear at the bottom of the item in the manuscript text. Items should be cropped to avoid the appearance of superfluous white space around items. Text on figures and graphs should be Helvetica to maintain consistency. Figures must not repeat data presented in the text or tables. Figures should be planned to appear to a maximum final width of either 80 or 175 mm. (3.5 or 7.0``). Complicated symbols or patterns must be avoided. Graphs and histograms should preferably be two-dimensional and scale marks provided. All lines should be black but not too heavy

or thick (including boxes). Colour only in photos or colour sensitive graphic illustrations. Extra charges will be levied for colour printing. Text: 1. Do not align text using spaces or tabs in references. Use one of the following: (a) use CTRL-T in Word 2007 to generate a hanging indent or (b) MS Word allows the author to define a style (e.g., reference) that will create the correct formatting. 2. Per APA guidelines, only one space should follow any punctuation. 3. Do not insert spaces at the beginning or end of paragraphs. 4. Do not use colour in text.

APPENDIX C

Author guidelines of journal selected for publication of Article 3.

Qualitative Research in Psychology

Instructions to authors

Qualitative Research in Psychology is dedicated to exploring and expanding the territory of qualitative psychological research, strengthening its identity within the international research community and defining its place within the undergraduate and graduate curriculum. The journal will be broad in scope, presenting the full range of qualitative approaches to psychological research. The journal aims to firmly establish qualitative inquiry as an integral part of the discipline of psychology; to stimulate discussion of the relative merits of different qualitative methods in psychology; to provide a showcase for exemplary and innovative qualitative research projects in psychology; to establish appropriately high standards for the conduct and reporting of qualitative research; to establish a bridge between psychology and the other social and human sciences where qualitative inquiry has a proven track record; and to place qualitative psychological inquiry appropriately within the scientific, paradigmatic, and philosophical issues that it raises.

Aims and Scope. Qualitative Research in Psychology aims to become the primary forum for qualitative researchers in all areas of psychology—cognitive, social, developmental, educational, clinical, health, and forensic—as well as for those conducting psychologically relevant qualitative research in other disciplines.

Types of Manuscripts. Qualitative Research in Psychology will publish the following types of paper:

1) Theoretical papers that address conceptual issues underlying qualitative research, that integrate findings from qualitative research on a substantive topic in psychology, that explore the novel contribution of qualitative research to a topic of psychological interest, or that contribute to debates concerning qualitative research across the disciplines but with special significance for psychology, 2) Empirical papers that report psychological research using qualitative methods and techniques, those that illustrate qualitative methodology in an exemplary manner, or that use a qualitative approach in unusual or innovative ways, 3) Debates, 4) Book reviews.

Submissions for special issues will normally be announced via an advertisement in the journal, although suggestions for topics are always welcome. Book reviews will normally be suggested by the Reviews Editor, although unsolicited reviews will be considered. The journal will also review other relevant media as well as qualitative research software.

All papers are refereed by, and must be to the satisfaction of, at least two authorities in the topic. All material submitted for publication is assumed to be exclusively for Qualitative Research in Psychology, and not to have been submitted for publication elsewhere. Priority and time of

publication are decided by the editors, who maintain the customary right to edit material accepted for publication if necessary.

Submission of Manuscripts. Qualitative Research in Psychology receives all manuscript submissions electronically via its ScholarOne Manuscripts site located at <http://mc.manuscriptcentral.com/uqrp> . ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, and facilitates the review process and internal communication between authors, editors, and reviewers via a web-based platform. ScholarOne technical support can be accessed at <http://scholarone.com/services/support>. Authors should upload three files in total: a separate title page with author names and institutional affiliations, a blinded main document, and a separate document for any tables and figures. The editorial office accepts papers in either UK or US page size formats. Manuscripts should be double-spaced throughout, especially the references. Pages should be numbered in order. The following items must be provided in the order given:

Title Page. Authors and affiliations: Authors should include their full name and the establishment where the work was carried out (if the author has left this establishment, his/her present address should be given as a footnote). For papers with several contributors, the order of authorship should be made clear and the corresponding author (to whom proofs will be sent) named with their telephone/fax/e-mail contact information listed.

Abstract. Please provide an abstract of approximately 150 words. This should be readable without reference to the article and should indicate the scope of the contribution, including the main conclusions and essential original content.

Keywords. Please provide at least 5–10 key words.

About the author: Please provide a brief biography to appear at the end of your paper.

Text. Subheadings should appear on separate lines. The use of more than three levels of heading should be avoided. Format as follows:

1 Heading

1.1 Subheading

1.1.1 Subsubheading

Footnotes should be avoided. If necessary, they should be supplied as end notes before the references.

References. The Harvard style of references should be used. The reference is referred to in the text by the author and date (Smith, 1997) and then listed in alphabetical order at the end of the article applying the following style: For a book: Hollway, W & Jefferson, T 2000, Doing qualitative research differently: free association, narrative and the interview method, Sage, London. For an edited book:

Brown, LM 2001, 'Adolescent girls, class, and the cultures of femininity', in MJ Packer & MB Tappan (eds.), *Cultural and critical perspectives on human development*, SUNY Press, Albany, NY. For a journal article: Madill, A, Jordan, A and Shirley, C 2000, 'Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies', *British Journal of Psychology*, vol. 91, pp. 1–20.

Acknowledgements. Authors should acknowledge any financial or practical assistance.

Tables. These should be provided in a separate file from the text and should be numbered in sequence. Each table should have a title stating concisely the nature of information given. Units should be in brackets at the head of columns. The same information should not be included in both tables and figures.

Figure captions. These should be provided together on a page following the tables.

Figures. Figures should ideally be sized to reproduce at the same size. All figures should be numbered consecutively in the order in which they are referred to in the text. Qualifications (A), (B), etc., can only be used when the separate illustrations can be grouped together with one caption. Please provide figures at the end of your paper on a separate page for each figure. Once accepted, you will be required to provide a best quality electronic file for each figure, preferably in either TIFF or EPS format.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files

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Search Engine Optimization. Search Engine Optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guide [here](#)

APPENDIX D

Permission to conduct research (Managers)

Informed consent (Participants)

Interview, focus group, journal questions

Mmogo-method[®] instructions

IQA axial code table

Toestemming om navorsing uit te voer

Geagte Bestuurder

As doktorale student van Sielkunde departement van die Noordwes-Universiteit (Potchefstroom) is ek tans besig met 'n navorsingsprojek wat die lewenskwaliteit van bejaardes ondersoek. Die doel van hierdie studie is om te bepaal watter konstruksie prominent uitstaan binne die konteks van 'n residensiële sorgfasiliteit en ook hoe ouer persone hul lewenskwaliteit konstrueer.

Die resultate van hierdie studie kan waardevol wees met betrekking tot die ontwikkeling van intervensies/ aanbevelings/ riglyne vir verhoogde lewenskwaliteit.

Hierdie navorsingsprojek fokus spesifiek op ouer persone van beide geslagte ouer as 60 jaar. Deelname aan hierdie projek is heeltemal vrywillig. Ek beoog om inligting by die deelnemers te verkry deur middel van onderhoude, fokusgroepe, joernaal inskrywings, visuele uitbeeldings en 'n vraelys. Die fasiliteit en deelnemers sal nie nodig hê om enige bykomende onkoste aan te gaan om aan die studie deel te neem nie. Deelnemers kan enige tyd van die studie onttrek. Toestemming om hierdie studie te doen is reeds van die Raad van Hoër Onderwys verkry.

Indien u toestemming sou verleen vir die navorsing om by die fasiliteit onder u bestuur plaas te vind, sal 'n persoonlik afspraak met u gemaak word om die verloop van die proses en reëlins te finaliseer.

Die resultate van hierdie navorsing kan moontlik in 'n wetenskaplike joernaal gepubliseer word of tydens 'n wetenskaplike konferensie aangebied word. Elke deelnemer se anonimiteit word gewaarborg.

U kan Lizanlé de Jager (PhD-student) by 0827737607 skakel indien u enige vrae oor die navorsing het.

Handtekening van bestuurder

Datum

Byvoorbeeld dank

L de Jager



Prof. V. Roos



Ingeligte toestemming om aan navorsing deel te neem

Geagte Deelnemer

As doktrale student van Sielkunde departement van die Noordwes-Universiteit (Potchefstroom) is ek tans besig met 'n navorsingsprojek wat die lewenskwaliteit van bejaardes ondersoek. Die doel van hierdie studie is om te bepaal watter konstruksie prominent uitstaan binne die konteks van 'n residensiële sorgfasiliteit en ook hoe ouer persone hul lewenskwaliteit konstrueer.

Indien u sou instem om vrywillig aan die navorsing deel te neem word daar van u verlang om die brief te onderteken wat dit sal bevestig. Inligting gaan op verskillende wyse ingesamel word, daar kan van u verwag word om 'n persoonlike onderhoud met die navorser te voer, om deel te wees van 'n fokusgroep of om in 'n joernaal te reflekteer. Verder kan u ook gevra word om 'n visuele uitbeelding van u persepsie van lewenskwaliteit te maak of om 'n vraelys in te vul. U persoonlike inligting sal streng vertroulik hanteer word.

U behou die reg om nie toestemming te verleen om aan die studie deel te neem nie of om enige tyd van die studie te onttrek.

Die resultate van hierdie navorsing kan moontlik in 'n wetenskaplike joernaal gepubliseer word of tydens 'n wetenskaplike konferensie aangebied word.

U kan Lizanlé de Jager (PhD-student) by 0827737607 skakel indien u enige vrae oor die navorsing het.

Ek _____, Ouderdom _____ het hierdie brief oor die studie gelees en verstaan die aard daarvan, asook die aard van my deelname daaraan, en ek stem hiermee in om aan die studie deel te neem.

Handtekening van deelnemer

Datum

Byvoorbeeld dank

L de Jager



Prof. V. Roos



Interview, focus group, journal questions

Semi-structured interviews and focus groups:

- Please tell me more about your QoL.
- Please share your perceptions on the nature of QoL.
- How would you define QoL?
- How did you formerly view and experience QoL?
- How do you experience QoL now?
- What contributes to your QoL?
- What inhibits your QoL?

Journals:

- Please define QoL in your own words.
- What are the things that currently provide you with QoL?
- What are the things that formerly gave you QoL?
- What are the things that contribute to your QoL?
- What are the things that inhibit your QoL?
- Please feel welcome to share any additional thoughts on QoL.

Mmogo-method® instructions

- Participants sat around a table where they constructed their visual representations simultaneously (see photos on the enclosed CD).
- An open-ended instruction was given: *‘Use the material in front of you and please construct a visual representation of anything that could tell me more about your QoL’.*
- The researchers analysed the visual representations by observing the constructed objects; the relationship between the objects, e.g. the distance between the objects; the actions in which the objects are involved; the relational context as well as the broader environment in which the objects are placed; and how the objects are related to the research question.
- The themes generated by the visual analysis were linked with themes that derived from the analysis of the textual data.

IQA AXIAL CODE LIST	
<p>Geagte Deelnemer</p> <p>Gedurende `n studie rakende die lewenskwaliteit van ouer persone in residensiële sorgfasiliteite is die volgende hooftemas bepaal n.a.v. individuele- en groeps gesprekke, visuele uitbeeldings van lewenskwaliteit sowel as onthullings in dagboeke van uself en mede-inwoners.</p> <p>Elke tema word hieronder omskryf n.a.v. die verdere gesprekke om elke tema te bevestig.</p>	
Spiritualiteit	<ul style="list-style-type: none"> • Die belang van `n persoonlike verhouding met God. • Vertroue in God om te ondersteun en te voorsien. • Deelname aan geestelike aktiwiteite. • Belang van `n geestelike gemeenskap en die ondersteuning wat dit bied.
Verhoudings	<ul style="list-style-type: none"> • Kwaliteit verhoudings met familie en vriende buite die oord. • Kwaliteit verhoudings met vriende, kennisse en personeel binne die oord. • Afwesige of gebrekkige verhoudings en verliese aan verhoudings. • Konflik binne verhoudings.
Gevoel van plek of behoort (omgewingsbeleving)	<ul style="list-style-type: none"> • Die belangrikheid van natuur. • Privaatheid en leefspasie. • Veiligheid en sekuriteit. • Finansiële vermoë om lewenstandaard in oord te handhaaf. • Geleentheid en beskikbaarheid van aktiwiteite by die oord (sosiaal, fisiek, stokperdjies).
Betekenisvolheid	<ul style="list-style-type: none"> • `n Gevoel van waarde deur vir iemand anders iets te beteken. • Leef met `n doel en nie net om besig te bly nie. • Dit wat as betekenisvol beskou word verander soos `n mens ouer word. Om dinge te bereik is minder belangrik as om waarde te vind in die hier en nou.

Gesondheid	<ul style="list-style-type: none"> • Bevredigende ouderdoms verwante liggaamlike en verstandelike vermoëns. • Liggaamlike onafhanklikheid. • Self regulering en verantwoordelikheid teenoor (gebalanseerde dieet, aktief wees). • Liggaamlike en verstandelike agteruitgang, verlies aan sintuiglike vaardighede, siekte, kroniese siektes en pyn.
Outonomie (selfbestuur/selfstandigheid)	<ul style="list-style-type: none"> • Word as 'n individu met eie kwaliteite beskou. • Vermoë om besluite te maak. • Bewustheid van en regulering van gedrag teenoor mense en die lewe. • Stereotipering wat alle ouer persone eenvormig maak of gelykstel aan kinders. • Self tevredenheid in die huidige lewensfase.

Gee asb u mening oor die invloed van hierdie ses hooftemas op mekaar.

U word versoek om telkens net een keuse uit te oefen by elke vraag.

Voorbeelde van sinne:

- Het u persoonlike verhouding met die Skepper en geestelike aktiwiteite saam met ander mense 'n invloed op u verhoudings met belangrike naby mense en met mense in die algemeen

Of

Het verhoudings met belangrike naby mense en met mense in die algemeen 'n invloed op u persoonlike verhouding met die Skepper en geestelike aktiwiteite saam met ander mense

Of

Daar is geen verband tussen die twee nie.
- Het die omgewing waar u nou is (naby natuur, privaatheid, ruimte, sekuriteit, of aktiwiteite) 'n invloed op u persoonlike verhouding met die Skepper en ander mense

Of

Het u persoonlike verhouding met die Skepper en ander mense 'n invloed op u belewenis van die omgewing

Of

Daar is geen verband tussen die twee nie

KIES ASB. DIE OPSIE (SLEGS EEN-) WAARMEE U DIE MEESTE SAAMSTEM VIR ELKE BLOK Merk met 'n kruisie (x)

1.Spiritualiteit het ‘n invloed Verhoudings	
Verhoudings het ‘n invloed op Spiritualiteit	
Daar is geen verband	
2.Spiritualiteit het ‘n invloed op Omgewingsbeleving	
Omgewingsbeleving het ‘n invloed op Spiritualiteit	
Daar is geen verband	
3.Spiritualiteit het ‘n invloed op Betekenisvolheid	
Betekenisvolheid het ‘n invloed op Spiritualiteit	
Daar is geen verband	
4.Spiritualiteit het ‘n invloed op Gesondheid	
Gesondheid het ‘n invloed op Spiritualiteit	
Daar is geen verband	
5.Spiritualiteit het ‘n invloed op Otonomie	
Otonomie het ‘n invloed op Spiritualiteit	
Daar is geen verband	
6.Verhoudings het ‘n invloed op Omgewingsbeleving	

Omgewingsbeleving het 'n invloed op Verhoudings	
Daar is geen verband	
7.Verhoudings het 'n invloed op Betekenisvolheid	
Betekenisvolheid het 'n invloed op Verhoudings	
Daar is geen verband	
8.Verhoudings het 'n invloed op Gesondheid	
Gesondheid het 'n invloed op Verhoudings	
Daar is geen verband	
9.Verhoudings het 'n invloed op Outonomie	
Outonomie het 'n invloed op Verhoudings	
Daar is geen verband	
10.Omgewingsbeleving het 'n invloed op Betekenisvolheid	
Betekenisvolheid het 'n invloed op het 'n invloed op Omgewingsbeleving	
Daar is geen verband	
11.Omgewingsbeleving het 'n invloed op Gesondheid	
Gesondheid het 'n invloed op Omgewingsbeleving	

Daar is geen verband	
12.Omgewingsbeleving het 'n invloed op Outonomie	
Outonomie het 'n invloed op Omgewingsbeleving	
Daar is geen verband	
13.Betekenisvolheid het 'n invloed op Gesondheid	
Gesondheid het 'n invloed op Betekenisvolheid	
Daar is geen verband	
14.Betekenisvolheid het 'n invloed op Outonomie	
Outonomie het 'n invloed op Betekenisvolheid	
Daar is geen verband	
15.Gesondheid het 'n invloed op Outonomie	
Outonomie het 'n invloed op Gesondheid	
Daar is geen verband	

APPENDIX E

Research report intended for the managers of the residential care facilities

Name of Residential Care Facility

Postal Address of Facility

April 2013

Dear Mr/Mrs

Thank you for granting me the opportunity to conduct research at the facility under your management as part of my PhD research. It is with pleasure that I report on the findings of my inquiry.

During the course of 2010 and beginning of 2011 I conducted a study with the aim to explore how older people that live in residential care facilities construct their quality of life (QoL). My concern with the QoL of older people in residential care evolved from long-term engagement in the context of residential care facilities as a research intern and a volunteer. As part of my fieldwork I read various government reports (Department of Social Development, 2007; 2010) and had many conversations with managers of facilities, care workers as well as residents.

Despite policies for older people that promote their well-being and QoL as well as many efforts by the personnel at facilities to keep residents as comfortable as possible, a bleak picture of QoL was often obtained. The notable increases in the numbers of older people as reflected in current population estimates of South Africa indicate that a rapidly growing number of older people are bound to opt for this sort of living arrangement within the next two decades. Thus I thought it might be helpful to provide managers, care givers, family members of residents and the residents themselves with an account of how the study found QoL to be constructed from the perspective of the older people themselves.

First of all it is important to note that older people are prone to reflect only on the positive aspects of their QoL, since the name of the construct in itself conveys positive characteristics. The study set out to obtain unbiased opinions of QoL by employing multiple data collection techniques as well as obtaining information from more than one facility. The nature of QoL for older people in residential care facilities as well as the contributors to and inhibitor thereof were explored.

The findings of the study revealed that QoL is informed by spiritual worldviews, interpersonal contexts and the maintained ability of older people to regulate aspects of their

own lives. The nature of QoL is also described as transitional since the things that are important in the construction of QoL change over time.

Six domains were elicited which seemed to comprise QoL, namely spirituality, health, relationships, meaningfulness, autonomy and sense of place. Each domain has contributors and inhibitors that influence the ability to experience QoL. In a spirit of cooperation, the contributors to and inhibitors of QoL are emphasised for your attention as well as for policy makers, care givers and family members.

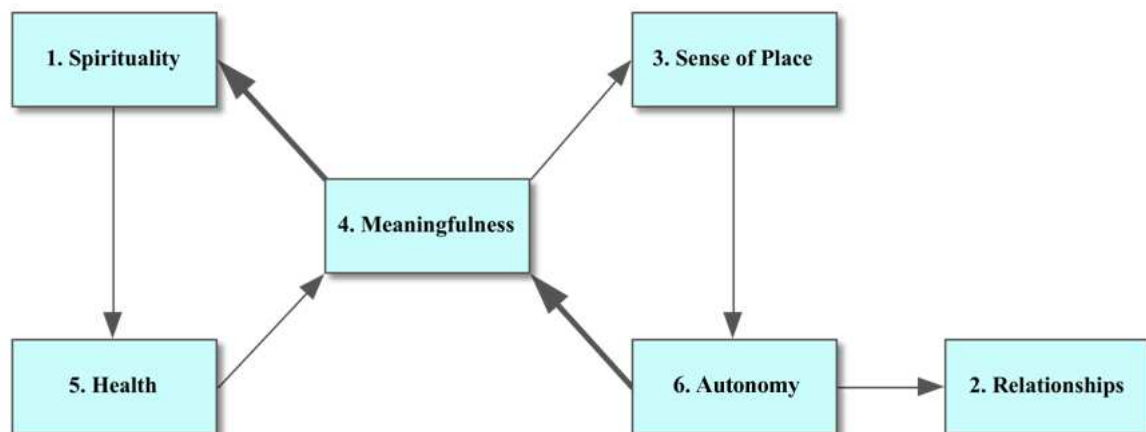
- *Spirituality* contributed to the older people's QoL in that they mentioned the supporting nature of a relationship with God. It was found to be a coping mechanism and provided participants with a spiritual support network. Traditional spiritual rituals and practices had an inhibiting effect when their needs for advancement in their spiritual growth were not met.
- *Relationships* contributed to QoL when participants had close familial and social relationships as well as positive relationships with the staff. The loss of relationships due to death and through conflict in relationships inhibited their QoL.
- *Health aspects* such as physical ability, physical independence, and satisfactory cognitive abilities contributed to QoL, whereas reduced physical and cognitive abilities, pain, long-term illness and the awareness of death inhibited it.
- *Meaningfulness* contributed to QoL in that the residents reported experiencing meaningfulness when they felt they had a purpose in life, felt useful and had new challenges to overcome. Boredom in care facilities inhibited the capacity of the study's participants to regard their lives as meaningful.
- *A sense of place*, another contributor to QoL, was gained from access to nature, privacy, safety and security as well as a fit between the individual and the physical structure of the facility. The loss of privacy, as well as financial constraints and feelings of isolation from broader society created a misfit between the individual and their sense of place.
- The final contributor to QoL, i.e. *autonomy*, was found to be attained through the maintained ability to have control over some aspects in life and freedom of choice in terms of diet, clothing, etc. Self-regulation in terms of behavioural, physical, financial aspects as well as perceived individuality added to autonomy. When participants felt that they were being treated like children or as a homogenous group,

their autonomy was inhibited. Furthermore, negative attitudes amongst themselves, loss of control and dependence on others also had inhibiting effects.

The domains of QoL were found to be interconnected and mutually informing, not as loose or separate ideas. Therefore, I explored the nature of the relations and the influences between the various domains.

The participants of the study judged the cause and effect relationships between the domains. They also indicated the direction of the influences caused by each domain, either exercising an influence *on*- or being influenced *by* the other domains. A conceptual model was elicited which proposed an explanation of older people's construction of QoL. QoL emerged as a complex system consisting of two feedback systems (i.e. [i]the physical ability to have a meaningful life facilitated through spirituality, and [ii] intra-personal meaningfulness in the environmental context which in turn influences the relational aspects of older people's lives).

Please consider the model below:



(This model should not be regarded as fixed and unalterable. It does however give some indication that all the domains of QoL are tied and not loosely structured and provides us with a new way of thinking about QoL in care facilities.)

Although the study revealed that perceived QoL is a personal state informed by multiple dimensions, it was found that residential care facilities do have the potential to influence QoL through their management, the physical environments, the nature of care plans and through their approaches to family and community.

Medical models of care in residential care facilities are discouraged, and person-centered care should be opted for. A more person-orientated model of care can be demonstrated by making an effort to allow residents to live comfortably and feel at home as supposed to feeling like they are institutionalised or in hospital. It is recommended that of the highest priorities should be privacy, dignity and residents' ability to make choices (according to their abilities).

On a practical level the following recommendations are proposed:

- It is recommended for facilities to create spaces and opportunities for older people to be together with friends and family members in a meaningful and caring manner. The privacy of residents ought to be regarded especially when people from outside of the facility come to visit.
- Avenues should be explored in which older people (who are still able to do so) could accumulate some revenue. Participants expressed the need for meaningful engagement, as well as being busy with things that have a purpose. Their revenue can be used towards upgrading social facilities such as the TV room or the outside barbeque area, or to sponsor regular social activities.
- Community work is recommended for those who are still able to extend a hand. Various participants reported that being engaged in some form of community work was meaningful to them.
- Spiritual activities and support groups ought to be initiated in facilities. Most of the participants in this study expressed the need for such engagement. Creative materials such as spiritual DVDs are a practical way of engaging a group of people in a spiritual activity, where the burden to keep the group intact and to prepare for such meetings does not rest on one person.
- Attention should be given to relationships between the residents and their care givers, as well as to conflict between residents. Residents are involved in these relationships on a daily basis and the research found that conflicts should be resolved and managed to optimise their QoL.
- Care giver burden can be lessened if the care givers themselves are made aware of the study's findings. This might also facilitate more positive relationships between personnel and residents.
- Engaging residents in activities merely for the sake of keeping them busy does not add quality to their lives. The emphasis should be placed on activities that have meaning to the group or individual concerned.

- Functional older people (physically and cognitively) seemed to be the only beneficiaries of recreational care plans in facilities. The less functional older people were found to be more isolated and in need of social interaction as they were not able to participate in many of the recreational activities offered by the facilities. It is recommended that facilities should be sensitive to the needs and abilities of the more frail residents and look for avenues to accommodate and integrate them into recreational care plans.
- The strengths and the potential of older people to deal with adversities associated with later life were revealed. These strengths ought to be nurtured.

In conclusion I would once again like to express my gratitude for the opportunity to have conducted this study. It is my sincere hope that the findings and recommendations will be useful to you as a manager as well as to the care workers and other personnel working in your facility.

Please feel welcome to contact me for any further information.

Yours sincerely

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