The quality of life of elderly people: A case study at a university senior

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Abstract

Aging is a phenomenon inherent to the individual that can be analyzed from many different perspectives. The main goal of this paper is to analyze the interdependence between the quality and life satisfaction, emotional intelligence and depression.
This research aims to study the importance of social support satisfaction and quality of life of older people; as well as verify the existence of depressive characteristics.
This study is ongoing and focuses on the retired population, who attends the University Senior. To conduct the research we decided to use the following instruments: Questionnaire of Health Status - SF-36 Scale, Scale, Life Satisfaction, Scale Veiga Emotional Competence and the Geriatric Depression Scale. This is a correlational and comparative study of exploratory nature, with quantitative analysis. The statistical data will be made on SPSS, statistical analysis program.

Keywords: Quality of Life, Life Satisfaction, Emotional Intelligence, Depression, Retired

INTRODUCTION

Society is constantly changing, and as such the social structure also receives fluctuations. Designate which begins the third age, is not as exhaustive. The threshold was taken into account the retirement age (65 years) but now it does not happen because people retire earlier and earlier, for reasons not relate to age, but with unemployment, disabling situations and early retirement, which makes it difficult to distinguish who should be considered elderly (Duarte, Days, Santana, Smith & Thofern, 2005).

From the demographic point of view we can see that there was an increasing elderly population. Portuguese society is growing older, and the population over 65 years represents, in Portugal 16.4% of the total population (Imaginary 2008).

According to WHO (World Health Organization, sd, cit. By Duarte et al., 2005) opened the third age between 60 and 65. This age is seen as marking the beginning of old age, but chronological and biological age differs from individual to individual, so there should be standardized.

Aging has implications for the functionality, autonomy, mobility and consequently quality of life of the individual (Carvalho, 1999). To be successful aging is necessary to take into account several dimensions: emotional (ability to cope with stressful life events, for example, health, physical functioning, personal problems), cognitive (problem solving), behavioral (ability to problem solving) (Santos, 2008, Fernandes 1999).

Theories of successful development sees the subject as pro-active, regulating the quality of life by setting goals and striving to achieve them, accumulating resources that are useful in adapting to change and actively involved in maintaining the well-being (Seabra, 1995).

Satisfaction of life is characterized as a personal and subjective assessment of each individual about how his life is close to its ideal (Diener, Oishi & Lucas, 2009).

In light of the cognitive and affective way to the subjective well-being, which translates into happiness when the individual is satisfied with the life and experienced more positive affect than negative (Keyes, Shmotkin, & Ryff, 2002).).

This subjective well-being corresponds to a personal assessment that each one makes of his life, characterized as a long-term assessment, not just a temporary state. Thus, the subjective well-being consists of two dimensions: the cognitive dimension, referred to as life satisfaction, and the emotional dimension, composed of positive affect and negative affections, however, is influenced by culture, personality traits of the individual, social support and socio-demographic characteristics related to lifestyle (Galinha & Ribeiro, 2005).

The Quality of Life bases its definition on the values that each social group attributes the way of life and this varies from season to season. The variables that contribute to the establishment of parameters of what is quality of life evolve, depending on cultural, economic and social (Dosil, 2004)

Several authors report that the quality of life is closely related to satisfaction and well-being. Boer (2002, cited by Santos, 2008) divided by three welfare components, one physical, one mental and one social. According to Neri (2001), the quality of life may have two dimensions: an objective which can be verified by outside observers, and a

subjective characterized based on the relationships that the subject and sets that seem satisfactory or not.

The findings in the emotional field and the interaction between emotion and cognitive processes in interdependence (Damasio, 1995), led to the expansion of the research in Emotional Intelligence. Gardner (1995) considered that the interpersonal intelligence was based on the ability to notice distinctions among others, moods, temperaments, motivations and intentions. Intrapersonal intelligence defined as the gateway to the emotions, access to the ability to differentiate emotions Gardner (1995).

To Bar-On (1997, cit. By Mayer, Caruso, & Salovey, 2000), emotional intelligence fits in non cognitive skills, knowledge and skills that enable properly handle the various situations of day-to-day. However Goleman (1997) argues that emotional intelligence influences the success you can have in various areas of life, particularly in the professional. Considers that the ability to be emotionally intelligent is not related to academic intelligence.

Depression involves a whole state of enormous complexity, which are encompassed several components, such as anxiety, agitation, worry, guilt feelings and experiences of unhappiness continues (Tan & White 1989). So the past is remembered with livings of guilt, this is denied by ideas of unworthiness and the future is locked experiencing ideas of disaster and death (Fernandes, 2000).

METHOD

This study is ongoing and focuses on the retired population, who attends the University Senior. This is a correlational and comparative study of exploratory nature, with quantitative analysis. The statistical data was made on SPSS, statistical analysis program (version-19).

Participants

Respondents were 43 subjects of both sexes, 20 (46.5%) were male and the remaining 23 females (53.5%).

The age of the subjects had an average of 68.59 (standard deviation (SD) = 8.402), with a mean age of male respondents 70.63 (SD = 9.112) and age of female respondents had an average of 66.82 (SD = 7.500), no significant differences between genders for the probability of significance (p) was higher than 5% .

For the status, it was found that the majority were married (62.8% corresponding to 27 individuals), no significant differences between genders for p is greater than 5% Concerning to the education, the majority had an average course (62.8% corresponding to 27 individuals), no significant differences between genders for p is greater than 5% .

Instruments

To conduct the research we decided to use the following instruments: Questionnaire of Health Status SF-36 Scale, Life Satisfaction, *Scale Veiga Emotional Competence* and the Geriatric Depression Scale.

The Questionnaire of Health Status (SF-36), was validated for the Portuguese population by Ferreira (2000a, 2000b). It consists of 36 self-response items covering eight dimensions of health status and to detect the positive, and negative health, they are: (a) Physical Function (b) Physical Performance (c) Bodily Pain (d) General Health (e) Vitality (f) function (g) Performance Emotional (h) Mental Health

The Life Satisfaction Scale was a cognitive component of well-being will be assessed by the Scale of Life Satisfaction of Diener et.al. (s.d., cit. by Neto, 2003). This scale consists of five items whose responses range from 1-7 on a Likert type scale. The coefficient of internal consistency is satisfactory (0.78), and correlates well all of the items (+ .50) showing that adaptation to the Portuguese population shows favorable psychometric properties. Thus, the scale appears to be suitable for the Portuguese population (Neto, 2003).

The Scale Veiga Emotional Competence (Veiga, 1999), is based on the model of Goleman (1997) emotional intelligence. This competence is measured/observed through the responses to 84 statements that have taken the behaviors and attitudes (expressed in situations) and how often did. The 84 items are divided into five sub-scales: a) Capacity Self-awareness, b) Capacity Self Motivation; c) Capacity Management Emotions d) whether the empathy e) Capacity Management Relationships in Groups.

The Geriatric Depression Scale was measured and adjusted by the Portuguese population Verissimo (1988). Since this is a straight-scale assessment with dichotomous responses (yes / no), consisting of thirty items.

Results

Subscales comparison of the Health State Questionnaire - SF-36 taking into account the age of the respondents (n = 43).

Taking into account the subject´s age, and after grouping into classes and using the nonparametric Kruskal-Wallis test, observed significant differences in the subscale "physical functioning" (X^2 = 8.822, df = 3, p = 0.032), “Physical performance” (X^2 = 10.524, df = 3, p = 0.015) and" social function "(X^2 = 9.356, df = 3, p = 0.025) (Table 1) belonging to the State Health Test.

In Table 1**,** was found that the “Physical function” in younger individuals had an average of the higher orders, and therefore they had better physical function. In the "physical performance", individuals with younger age also showed better performance because the average of the orders was higher than in the same groups. For the "social function", those aged between 60 and 70 years had an average of the highest orders **of** followed by individuals under the age of 60, ie, individuals under age had better social function (Table 1).

Table 1. Kruskal-Wallis test for comparison of the subscales of the Health State Questionnaire - FS-36, taking into account the age of the respondents (n = 43).

	Age	N	Average Orders	X2	d.f	p
Function physical	Below 60	7	23,71	8,822	3	0,032
	60 to 70 years	18	20,08			
	70 to 80 years	5	9,60			
	Above 80 years	5	10,90			
	Total	35				
Physical performance	Below 60	7	25,07	10,524	3	0,015
	60 to 70 years	18	21,44			
	70 to 80 years	8	11,13			
	Above 80 years	4	13,13			
	Total	37				
Social function	Below 60	7	17,93	9,356	3	0,025
	60 to 70 years	16	21,63			
	70 to 80 years	7	14,07			
	Above 80 years	4	6,25			
	Total	34				

Legenda: X^2 – Chi-square value; d.f. – degrees of freedom; p – probability of significance

Spearman Correlational Test of the subscales of the Questionnaire of Health State (SF-36) with the subscales of the Scale Veiga Emotional Competence.

Using the test nonparametric Spearman correlation for a significance level of 5% was found that the subscales "physical function" (FF), "physical performance" (DP) and "social function" (FS) of the State Questionnaire health (SF-36) was not correlated with any of the subscales range of Emotional Competence Veiga (Table 2).

The subscale "corporal pain" (DC) of the SF-36 is positively correlated with the subscale "self-motivation" (AM) (r = 0.406, p = 0.016) of Scale Veiga Emotional Competence, i.e., the corporal pain greater self-motivation (Table 2).

The subscale "general health" (SG) of the SF-36 was positively correlated with the subscale "self-motivation" (AM) (r = 0.518, p = 0.002) of the Scale Veiga Emotional Competence, i.e., when the general health is better self-motivation is higher (Table 2).

The subscale "vitality" (V) of SF-36 is positively correlated with the subscale "self-motivation" (AM) (r = 0.534, p = 0.002) of the Scale Veiga Emotional Competence, i.e., when there is vitality exists more self-motivation (Table 2).

The subscale "emotional performance" (DE) of the SF-36 was also positively correlated with the subscale "self-motivation" (AM) (r = 0.432, p = 0.014) of the Scale Emotional Competence Veiga, when there are emotional performance exist greater self-motivated (Table 2).

Finally, the subscale "mental health" (SM) of the SF-36 was also positively correlated with the subscale “self-motivation” (AM) (r = 0.368, p = 0.038) of the Scale Veiga Emotional Competence, ie, mental health is correlated directly to self-motivation (Table 2).

Table 2. Correlational Spearman Test of the subscales of the Questionnaire of Health Status (SF-36) with the subscales of the Scale Veiga Emotional Competence.

		AC	GE	AM	Em	GRP
FF	r	,046	,045	,247	,199	,247
	p	,808	,808	,181	,293	,147
	N	31	32	31	30	36
DP	r	-,034	,050	,303	-,057	,186
	p	,857	,781	,087	,758	,277
	N	30	33	33	32	36
DC	r	,118	,111	,406	,057	,240
	p	,522	,526	,016	,753	,141
	N	32	35	35	33	39
SG	r	,285	,176	,518	,007	,129
	p	,120	,319	,002	,967	,440
	N	31	34	34	33	38
V	r	,368	,264	,534	,351	,293
	p	,054	,151	,002	,067	,098
	N	28	31	30	28	33
FS	r	,148	,009	,186	,089	,129
	p	,452	,963	,334	,652	,468
	N	28	30	29	28	34
DE	r	,110	-,009	,432	,207	,116
	p	,564	,960	,014	,263	,499
	N	30	33	32	31	36
SM	r	,079	,027	,368*	,276	,184
	p	,685	,880	,038	,126	,283
	N	29	33	32	32	36

Legend: ED - Geriatric Depression Scale; ESV - level of satisfaction with life; FF - physical function, SD - physical performance; DC - Pain corporal, GS - general health; V - vitality, FS - social function; DE - Performance emotional, MS - Mental Health; AC - self; GE - managing emotions; AM - motivation; EM - Empathy; GRP - relationship management groups.
r - Correlation coefficient of Spearman, p - significance probability, N - number of respondents

Spearman Correlational Test of the Geriatric Depression Scale (ED), the subscales of the Health State Questionnaire (SF-36) and the subscales of the Scale Veiga Emotional Competence

Using the Non-Parametric Correlation Spearman Test and considering a significance level of 5% was found that the Geriatric Depression Scale (ED) was negatively correlated with the "physical function" (FF) (r = -0.595, p = 0.000), “physical performance” (DP) (r = -0.483, p = 0.002), “corporal pain” (DC) (r = -0.467, p = 0.002), “general health” (SG) (r = -0.706, p = 0.000), “vitality” (V) (r = - 0.584, p = 0.000), “social function” (SF) (r = -0.625, p = 0.000), “role emotional” (DE) (r = -0.400, p = 0.012), “mental health” (SM) (r = -0.522; p = 0.001), “motivation” (AM) (r = -0.500, p = 0.002) (Table 3). According to the same information it was found that the higher the depression, was lower the “physical function”, “physical performance”, “body pain”, “general health”, “vitality”, “social function”, “role emotional”, “mental health” and “self-motivation”.

Table 3. Correlational Spearman Test of the Geriatric Depression Scale (ED), the subscales of Health Status (SF-36) subscales and the Scale Veiga Emotional Competence.

		ESV	FF	DP	DC	SG	V	FS	DE	SM	AC	GE	AM	Em	GRP
ED	r	-,243	-,595	-,483	-,467	-,706	-,584	-,625	-,400	-,522	-,175	-,134	-,500	-,125	-,172
	p	,117	,000	,002	,002	,000	,000	,000	,012	,001	,337	,442	,002	,488	,294
	N	43	37	39	42	41	36	36	39	38	32	35	35	33	39

Legend: ED - Geriatric Depression Scale; ESV - level of satisfaction with life; FF - physical function, SD - physical performance; DC - Pain corporal, GS - general health; V - vitality, FS - social function; DE - Performance emotional, MS - Mental Health; AC - self-consciousness; GE - managing emotions; AM - motivation; EM - Empathy; GRP - relationship management groups.
r - Spearman correlation coefficient, p - significance probability, N - number of respondents

Discussion/C**onclusion**

Aging is a period marked by biological implications, physiological, social, economic and political present in the daily lives of individuals (Figueiredo, 2007)

As we see through the subscale of the Health State Questionnaire that "physical function" and "physical performance" have less affected in subjects with younger age, which is consistent with the evolutionary process of aging. According to Sousa, Figueiredo and Cerqueira, (2004) biological aging leads to progressive decrease in the efficiency of body functions.

It was also observed that in the subscale "social function" of the same questionnaire the subjects aged 60-70, followed by those under the age considered to be active in their social function. These results agree with Henrard (1997) and Sousa et. al (2004) who defend the creation of a new social role as the beginning of the reform, ie, loss of social status on the work that you had and consequently the removal of their social networks.

However Fonseca (2005) defends that individual should keep an active lifestyle to when passage to retirement so that make it more adaptive. The same author also notes that the subjects should start new activities (volunteer, senior university ...), while achieving the goals and starting new relationships. Thus social relations act as protective factor in problem situations and / or recovery factor in promoting cope with such situations (Fonseca, 2005). The lifestyle is extremely important in old age (Dean, 1995).

The results show us that when there is corporal pain greater self-motivation, and for Caspi and Elder (1986) each individual tends to act differently to similar situations, influenced by their values, experiences and expectations.

Therefore satisfaction with life is a multidimensional concept (physical, psychological, social), bipolar (positive / negative) and changeable (Pascoal, 2004) which allows a better understanding of the results.

So it is important keep in mind the emotional factor that evaluates the subject's life. Cooper (1997) defends that emotional intelligence is the ability to sense, understand and effectively apply the power and acumen of emotions, using them in favor of the subject.

Being consistent with the result which states that when there is an increased emotional performance of self-motivation. This ability to control feelings and emotions, knowing discriminates them and using them allows you to control themselves and engaging in social relations (Salovery & Mayer 1990; Neta, & Garcia Gallardo, 2008). Thus it may

be a promoter of mental health, as verified in the results obtained in that the higher the better mental health self-motivation.

Finally our results indicate that the depressive state depending on the level will become limited to the subject, the higher the depression lower physical function, physical performance, body pain, general health, vitality, functions social, emotional performance, mental health and self-motivation. Therefore the condition manifested depressive mood disorders, affective disorders, such as emotions of sadness and fear (Wolpert, 2000). However depression can be minimized by the perspective of the living subject's satisfaction, so that it is characterized by levels (Neri, 2001).

The successful aging should be adaptive and flexible to new challenges (Freire, 2000, Gyll, 1980), experiencing the stages of human development with quality of life (Paúl & Fonseca, 1999). It is important not to overlook the emotional component that helps in improving the performance of the subject in so longed quality of life (Goleman, 1995)

REFERENCES

Almeida, L.S., Guisande, M.A. & Ferreira, A.I. (2009). *Inteligência: perspectivas teóricas*. Coimbra: Almedina.

Bar-On, R.; Parker, J. (2002). *Manual de Inteligência Emocional – Teoria e aplicação em casa, na escola e no trabalho.* Porto Alegre: Artmed

Carvalho, J. (1999). Aspectos metodológicos no trabalho do idoso. In: J. Mota & J. Carvalho (Eds.), *Actas do seminário de qualidade de vida no idoso: o papel da actividade física.* (pp.306-327). Porto: Faculdade de Ciências do Desporto e de Educação Física

Caspi, A.; & Elder, G. H. E. (1986). Life Satisfaction in Old Age: Linking Social Psychology and History. *Journal of Psychology and Aging*, 1(1), 18-26.

Cooper, R.,& Sawaf, A. (1997), *Inteligência Emocional na Empresa.* São Paulo: Editora Campus.

Damásio, A. (1995). *O Erro de Descartes, Emoção, Razão e Cérebro Humano* (9ª edição). Mem Martins: Europa América

Dean, K., Colomer, C., & Pérez-Hoyos, S. (1995). Research on lifestyles and health: searching for meaning. *Social Science and Medicine*, *41*, 845-855.

Diener. E.; Oishi, S.; & Lucas, R. E. (2009). Subjective Well-Being: The Science of Happiness and Life Satisfaction (pp. 187-194). In C. R. Snyder & S. J. Lopez (Eds.). *Oxford Handbook of Positive Psychology*. Oxford: Oxford University Press.

Dosil, J. (2004). *Psicologia de la actividade fisica y del desporte*. Madrid: McGraw-Hill.

Duarte, V., Dias, D., Santana, M, Soares, M. & Thofern, B. (2005). A perspectiva do envelhecer para o ser idoso e a sua família. *Família Saúde Desenvolvimento, 1*, 42-50.

Fernandes, A. (1999). *Velhice e sociedade*. Oeiras: Celta

Fernandes, P. (2000). *A depressão o idoso.* Coimbra: Quarteto.

Ferreira, P. L. (2000a). Criação da versão portuguesa do Mos SF-36: Parte I – Adaptação cultural e linguística. *Acta Médica Portuguesa, 13*, 55-66.

Ferreira, P. L. (2000b). Criação da versão portuguesa do Mos SF-36: Parte II – Testes de validação. *Acta Médica Portuguesa, 13*, 119-127.

Figueiredo, D. (2007). *Cuidados familiares ao idoso dependente*. Coimbra: Climepsi.

Fonseca, A. (2005). O envelhecimento bem sucedido. In: P. Constança & A. Fonseca (Coord.), *Envelhecer em Portugal: Psicologia, saúde e prestação de cuidados* (pp. 281-311). Lisboa: Climepsi

Fontaine, R. (2000). *Psicologia do envelhecimento*. Lisboa: Climepsi.

Freire, S. (2000). Envelhecimento bem-sucedido e bem-estar psicológico. In: A. Neri & S. Freire (Eds.). *E por falar em boa velhice* (pp.21-31). Campinas: Papirus.

Galinha, I. & Ribeiro, J. L. P. (2005b). História e evolução do conceito bem-estar subjectivo. *Psicologia, Saúde & Doenças 6*, 2, 203-214.

Gardner, H. (1995). *Inteligências Múltiplas. A teoria na prática*. Porto Alegre: Artes Médicas.

Goleman, D. (1995). *Inteligência Emocional. A Teoria Revolucionária que redefine o que é ser inteligente.* Brockman, Inc: Editora Objectiva Lda.

Goleman, D. (1997). *Inteligência Emocional*. Lisboa: Temas e Debates.

Goleman, D. (1999). *Trabalhar com Inteligência Emocional.* Lisboa: Temas e Debates.

Goleman, D. (2001). *Inteligência Emocional*. Lisboa. Temas e Debates

Gyll, J. (1980). Etiologia do envelhecimento. *Revista Ruiti*, vol. II, nº 8, pp 66-75.

Henrard, J. (1997). Les processus de vieillisement et l'âge de la vieillesse. In: Actualité et dossier en santé publique, nº21.

Keyes, C. L. M.; Shmotkin, D.; & Ryff, C. D. (2002). Optimizing Well-Being: the Empirical Encounter of Two Traditions. *Journal of Personality and Social Psychology*, 82(6), 1007-1022.

Marques, A. & Santos, Z. (1989). Aspectos na 3ª idade. *Psiquiatria Clínica,* 271-275.

Mayer, J.D., Caruso, D.R. & Salovey, P. (2000). Emotional Intelligence meets traditional standards for an intelligence. *Intelligence, 27* (4), 267-298.

Neri, A. (2001). *Desenvolvimento e envelhecimento: perspectivas biológicas psicológicas e sociológicas.* São Paulo: Papirus.

Neta N., García E., Gargallo, I. (2008) A Inteligência emocional no âmbito académico: Uma aproximação teórica e empírica/ Emotional intelligence in the academic environment:A theoretical and empirical approach – *Psicologia Argumento, 26* (52), 11-22

Neto, F. (2003). *Estudos de psicologia intercultural: Nós e os outros*. (2ª ed.) Lisboa: Fundação Calouste Gulbenkian.

Paschoal, S. (2004). Qualidade de vida na velhice. In E. Freitas, L. Py, F. Cançado, J. Doll & M Gorzoni (Eds.). *Tratado de Geriatria e Gerontoligia* (pp.149-163). Rio de Janeiro: Guanabara Koogan.

Paúl, M. C. & Fonseca C. (1999). A saúde e qualidade de vida dos idosos. Psicologia, Educação e Cultura. III.

Salovey, P., & Mayer, J. (1990). Emotional Intelligence. *Imagination, Cognition, and Personality, 9*, 185-211.

Santos, A. (2008). *Qualidade de vida e solidão na 3ª idade*. (Monografia de licenciatura em psicologia). Porto: Universidade Fernando Pessoa.

Santos, S., Santos, I., Fernandes, M & Henriques, M. (2002). Qualidade de vida do idoso na comunidade: aplicação da escala de Flanagan. *Revista Latino Americana de Enfermagem, 10* (6), 757-764.

Sousa, L.; Figueiredo, D. & Cerqueira, M. (2004). Envelhecer em família. Porto: Ambar.

Teixeira, J. & Branco, A. (1989). Fenomenologia da dor moral. *Psiquiatria Clínica,* 10, (1), 31-34.

Weinberg, R. & Gould, D. (2001). *Fundamentos da psicologia e do esporte e do exercício.* São Paulo: Artmed

Wolpert, L.(2000). *A psicologia da depressão*. Lisboa: Editorial Presença