This chapter will illustrate how researching the concept of quality of life from an occupational perspective can generate predictive knowledge to support occupational therapy. Hocking (2000) suggested that it is valid to conduct research that demonstrates the influence of occupation on other phenomena such as health. This Q methodology study was undertaken to investigate the perceptions of healthy individuals over 50 years of age of their quality of life.

**Literature**

**Defining Quality of Life**

There are many definitions of *quality of life* (Kind, 2003). Bowling and Normand (1998) considered it to be a broad concept, greater than just health status and one that takes social well-being into account. Bogousslavsky, Hommel, and Bassetti (1998) suggested that there are many different issues to take into account when considering what constitutes quality of life. These include orientation, physical independence, mobility, occupation of time, social integration, and economic self-sufficiency (Bogousslavsky et al., 1998). Traditionally, health-related quality of life has been described as feelings one had as a response to change in health (Guyatt et al., 1997) and not on aspects such as finances or the quality of the environment. The distinction between quality of life and health-related quality of life, however, is not clear. One aspect may influence the other, making it difficult to separate all of the contributing viewpoints to quality of life. Health-related quality of life is now considered the extent to which an individual person maintains physical, emotional, and intellectual function, as well as the ability to perform in valued activities within the workplace, family, and community (Naughton & Shumaker, 2003).

**Quality of Life Dimensions**

Cella and Nowinski (2002) described the dimensions of quality of life as including physical, functional, social, and emotional well-being but not external contributors, such as the environment and work influences. Harvey (1993) argued that quality of life is in fact closely connected with how an individual carries out his or her daily routine and the relationship between his or her environment, choices, and
behavior. However, Brownson and Marjorie (2001) acknowledged that health and disability can affect how individuals carry out their daily routines, how they function in their environment, their choices, and their behaviors.

Felce (1997) suggested three key aspects to quality of life: objective life conditions, subjective feelings of well-being, and personal values and aspiration. Both he and Hammell (2004a) emphasized the importance of the subjective viewpoint when defining quality of life.

**Choice, Control, and Quality of Life**

The Canadian Association of Occupational Therapists (1997) also noted that quality of life relates to people having choice and control in their lives. Meaningful occupations may not only influence the quality and meaning of living but also survival itself (Hammell, 2004a).

Many researchers have identified the importance of control (the exercise of choice) to the experience of a life worth living with a serious illness or impairment (Abresch, Seyden, & Wineinger, 1998; Conneely, 2003; Hammell, 2004b; Laliberte Rudman, Valiant, Cook, & Polatajko, 1997; Plahuta et al., 2002; Vrkljan & Miller Polgar, 2001). Yerxa et al. (1989, p. 5) stated that “to engage in occupations is to take control.” Research has found that people whose lives have been disrupted by illness or injury such as AIDS and spinal cord injury often made conscious decisions to take control of their lives (Carpenter, 1994; Gloersen et al., 1993; Hammell, 1998; Reynolds, 2003; Vrkljan & Miller Polgar, 2001). A key manner in which they did this was through reengagement in occupations they found personally meaningful. It has been suggested that people gain a sense of control by choosing, shaping, and managing their daily occupations (Clark & Jackson, 1989; Hammell, 2004a). The strong emphasis placed on self-determination by people whose lives have been disrupted by illness or impairment, as well as their perceived need to be in control of their own lives, supports a client-centered approach to occupational therapy (Hammell, 2004a). Central to the experience of quality of life is the ability and opportunity to enact choices and assert control over one’s occupations and one’s aspirations.

**Occupational Therapy Literature and Quality of Life**

The occupational therapy literature defines many concepts that surround overall well-being and may be equated to quality of life. Laliberte Rudman et al. (1997) found in a qualitative study that physical, social, and mental activity is reported to contribute to the well-being and quality of life of older adults. The participants of the study described activities as essential to continue one’s existence and to promote one’s sense of well-being. Jackson, Carlson, Mandel, Zemke, and Clark (1998; also see Chapter 25) found in their study of well elders that engaging in meaningful occupation was essential to well-being in older adults. Four contributing qualities of occupation were highlighted: (a) the need to control one’s participation in the activity, (b) participation in new occupations, (c) changing the environment to increase accessibility to an occupation, and (d) maintaining a social connectedness through the occupation. These reflect some of the issues that have been also explored in a qualitative study of quality of life of elderly Chinese persons (Lau & McKenna, 2002). In particular, the “locus of control” (Lau & McKenna, 2002, p. 210) is reported to be an important issue that contributes to the quality of life of elderly Chinese persons. The importance of an individual having control may be attributed to its relationship with motivation.

Christiansen (1994) proposed that having control of one’s situation or having free choice contributes to an individual’s intrinsic needs and thus increases motivation. Although motivation as a concept is not the purpose of this chapter, it has strong links with occupation and contributes to the domains that make up quality of life (Christiansen, 1994; Felce, 1997). Motivation has also been seen to link directly with the value one may place on an activity that is meaningful to oneself. Naughton and Shumaker (2003) stressed the importance of understanding health-related quality of life as the value an individual places on activities, rather than on how well that person performs these activities.

**Occupation and Quality of Life**

Occupations enrich lives. Being able to do something that is meaningful enhances daily existence. But this is a very individualized experience. Rollerblading may bring excitement to an uneventful day for one person, whereas being able to sit and talk to a loved one may be pleasurable to another person. The phrase *quality of life* encompasses this concept. However, quality of life can mean different things to different people. For some, quality of life is being involved in outdoor sports, for others this phrase means reading to one’s children, and to still others, quality of life may mean simply being alive and able to interact in some meaningful way with others. It is critical that the individual be able to define his or her significant occupations (Hinojosa, Kramer, Royeen, & Luebben, 2003).

Yuan (2001) highlighted the belief that quality of life appears to be directly related to a person’s capability or “the ability or the potential to do or to be something” (p. 128). This is consistent with Wilcock’s (1993) description of occupations as the mechanism by which individuals express their value and worth to society through achievement.

The Quality of Life Research Unit at the University of Toronto identified quality of life as the degree to which a person enjoys life’s possibilities in three major domains: being,
belonging, and becoming. The being domain is inclusive of personal identity and personal physical, psychological, and spiritual viewpoints. The belonging domain includes personal fit within the physical, social, and community environment. The becoming domain includes engagement in purposeful activities to meet personal needs and goals, including those of a practical, leisure, and growth nature.

Do Rozario (1992) identified five principal themes to illustrate peoples' perceptions and experiences related to coping viewpoints that facilitate health and well-being. These are the power of hope, the need for personal control, the contribution of positive external support, the need for meaningful activity and creative participation in life, and the healing effect of spiritual experiences.

Congruent with the self-focused and individualistic values of Western culture, occupational therapy theory has traditionally privileged goal-oriented, purposeful occupations that have economic and social benefits. However, the evidence base supporting the effectiveness of this approach is inconclusive at best. Research supports the importance of engagement in purposeful occupations when these are personally meaningful and valuable to the individual (Gloersen et al., 1993; Hammell, 2004b; Vrkljan & Miller Polgar, 2001). However, despite an alleged commitment to meaningful occupations, occupational therapists have only rarely explored the meaning of occupational engagement (Vrkljan & Miller Polgar, 2001) or whether engagement in purposeful occupations is sufficient to imbue life with meaning (Hammell, 2004b).

Rationale for This Research

The above research challenged our understanding of quality of life from an occupational perspective. An initial study was conducted to establish the perceptions of quality of life of individuals with neurological conditions (Corr & Palombi, 2009). The findings suggested three viewpoints of quality of life relating to independence, choice, and control; maintaining dignity, values, and aspirations; and actively contributing to society. Though it was thought that these findings helped occupational therapists understand this client group and their needs, it also raised the question as to what views individuals without a neurological condition held on quality of life.

Methods

There is a consensus in the literature that quality of life is a complex human phenomenon that is difficult to measure and may not always be measured when using standardized quality of life questionnaires. It is therefore desirable to approach this concept with a form of research that can illuminate its subjective nature (Vestling, Ramel, & Iwarsson, 2005). According to Iso-Aloha (1980), the most important aspect of quality of life is perceptions. It is the individual’s own perceptions that underlie his or her personal definition of the quality of life.

Q methodology is an approach that draws on both qualitative and quantitative paradigms of research (Corr, 2006). British physicist-psychologist William Stephenson invented Q methodology in 1935 (Brown, 1996). Since then, Q methodology has received much attention in the sociology and political science literature (Brown, 1996). It was designed by Stephenson to provide a basis for a science of subjectivity. It is a method of measuring subjective views in a mathematical and rigorous fashion, thereby combining the strengths of qualitative and quantitative research (Brown, 1996). The value of Q methodology for identifying opinion clusters for a studied population (Cross, 2005; Valenta & Wigger, 1997; Watts & Stenner, 2012) suggested it as being appropriate for exploring perceptions of quality of life by healthy adults.

It was intended to explore the concept of quality of life in a qualitative way, in order to allow space for subjectivity and not influence the results and to provide the researchers with a clear reflection on the needs of the client group.

The first step in Q methodology is the development of a sort pack of statements relevant to the topic being studied (Corr, 2006). A list of statements, or statement pack, is generated from the literature using everyday language. Then, the participants sort these statements via a ranking process, or Q-sort, to express their point of view. After administration of the Q-sort, interpretation of the data uses statistical analysis to complete a viewpoint analysis (Corr, 2001). The findings are viewpoints that present the combined perspectives of the participants. Q methodology is a useful tool for occupational therapists to use for exploring attitudes to illness, health (Cross, 2005), and occupations (Corr, 2006).

Developing the Q-Sort

The Q-sort for this study was developed using current quality of life literature in order to ensure a broad spectrum of opinions (McKeown & Thomas, 1998). Key articles that defined, explored, and described issues, concepts, and dimensions of quality of life in older people or in persons with a neurological population were explored. Ninety-seven statements relating to quality of life were extrapolated from the key articles. These were then grouped into categories such as health, contributing to society, and self-realization.

In order to have equal representation in the statement pack of all categories and to maintain the spectrum of opinions (McKeown & Thomas, 1998), the 17 categories were merged into 7. These were health; independence, choice, control; emotional well-being; family, friends, and intimacy; finance and civic well-being; being productive; and beauty.

Categories with only one statement were considered equally important to the others and were represented in the statement pack. A thorough literature review is essential to
address content validity of the Q-sort (Valenta & Wigger, 1997). Face validity is addressed by leaving the statements in everyday readable language that is appropriate for the participants in the study (Valenta & Wigger, 1997).

Next, duplicate statements were eliminated. Statements that were similar were combined or eliminated. Statements that were ambiguous or difficult to understand were simplified. Although further minor changes were made, the statements were not further reduced in this phase beyond 41 statements in English. Corr, Phillips, and Capdevila (2003) found that, for participants who had had a stroke, sorting 47 statements became tiring and reduced concentration.

Because the participants in this study were individuals from a community center in Italy, the statements were then translated and checked for clarity by four Italian individuals. As a result, the statement pack was further reduced to 37 statements. Certain concepts were eliminated because they become redundant with translation. The statements were then back-translated into English to ensure that the translation was accurate. Table 20-1 contains examples of statements in the final pack.

### Administering the Q-Sort

Once the final Q-sort was developed, a grid with the −4 to +4 spectrum was created (Figure 20-1). The grid enabled participants to place statements in the position they wanted along a least agree to most agree continuum.

### Participants

A convenience sample was recruited from all individuals who participated in various activities in a community center in Italy. Individuals volunteering for the study gave their name to a secretary who set up an appointment. All individuals over the age of 50 years were included unless they had reading, cognitive, or speech problems that might have affected their understanding or execution of the Q-sort task.

All potential participants were given an information sheet and consent form to read by the secretary of the community center. Further verbal explanation was given as necessary. Participants could withdraw at any stage of the research. The study was approved by the School of Health Ethics Committee at the University of Northampton, United Kingdom.

A total of 22 participants were recruited for the study. Ten (45.5%) were male. Their ages ranged from 53 to 83 years old. The mean age was 68 years (SD = 8.4).
Seventeen (78%) of the participants were pensioners and 8 (22%) were still employed. All participants lived at home with their families and were independent in their daily activities as well as driving or using public transport to move around in the community.

**Data Collection**

The participants carried out the sorting process seated at a table in the community center. A large grid was drawn on a piece of cardboard and then cut out. The participants used this to sort out their statements, which were on individual cards. One statement was typed on each card. They were first asked to divide their cards into three piles—first pile “most agree” cards, second pile “least agree” cards, and third pile all the statements in between. This was in order to facilitate the sorting process of numerous statements on the grid. The “most agree” pile would be prioritized on the positive right end of the large grid. The “least agree” pile would be sorted out on the negative left end of the grid and the “middle pile” in the middle of the grid. Only one statement could be placed in one square of the grid. The participants could not place two statements in one square of the grid. They were urged to prioritize each statement. When completed, the participants were able to see all of their statements placed on the grid and had the opportunity to make any final changes. Each sorting session lasted approximately 1 hour and the participants were invited to make further comments. Once completed, the researcher recorded all of the statement numbers and comments made by the participants on a smaller representation of the grid on a piece of paper.

**Research Process Challenges**

There were a number of challenges to overcome. First, the translation of the statements from English to Italian required carefully checking to ensure that there was no loss of meaning in translation. There was also a requirement to ensure that the statements were culturally relevant to an Italian population. The nationality mix of the research team and bilingual skills of some research team members ensured that this was not a problem.

A second challenge was locating a healthy population of the right age range who did not have a neurological condition. A community center was determined to be the best location because it was well attended by older people directly from the community, was easily accessible by the research team, and had sufficient space to undertake the data collection.

Explaining the purpose of the study to the participants was also a challenge. They were aware that the research team consisted of people in health care professions but it was necessary to conduct an initial interview with each participant to explain that the study was not about health services but about their perceptions of their quality of life. It was felt that these interviews ensured that the participants understood the research and their involvement in it to their satisfaction.

**Statistical Analysis**

The completed Q-sorts were analyzed using PQMethod, a data input computer package specific for Q-sort analysis. The viewpoint extraction method used was principal component analysis with varimax rotation (McKeown & Thomas, 1998) and automatic flagging. Statistical analysis typically follows three stages in Q methodology: correlation, viewpoint analysis, and computation of viewpoint scores (McKeown & Thomas, 1998).

In this study, the correlation between sorts identified which individual sorts (participants) correlated significantly with each other in their opinion of what quality of life means to them, using a standard error \((SE = 1/\sqrt{N})\) of 0.40. The correlation process identifies like groups of opinions, which are called viewpoints (Brown, 1996). Each viewpoint has an eigenvalue that indicates the significance of the viewpoint. This is calculated by squaring the viewpoint loadings (i.e., how much each sort, or participant, loads onto a viewpoint and therefore represents the proportion of variance; McKeown & Thomas, 1998). An eigenvalue needs to be greater than the numerical value of 1 for a viewpoint to be considered significant.

There are several techniques that can inform decision making in regard to how many viewpoints to retain (Bryant, Green, & Hewison, 2006). One recommendation is to select viewpoints with eigenvalues above the numerical value of 1. Mrtek, Tafesse, and Wigger (1996) recommend using the Q-sorts of individuals with a viewpoint loading of 0.6 or greater \((p < .001)\). Eight viewpoints were identified with having a significant value (eigenvalue > 1). However, four of these were determined only by one or two Q-sorts or participant viewpoints. Therefore, it was decided that the four significant viewpoints or opinions with more than two Q-sorts or participant viewpoints would be extracted for this study. Each viewpoint or opinion is represented as a Q-sort grid (see Figure 20-1). This facilitates comparison between the four viewpoints (McKeown & Thomas, 1998).

**Results**

Four viewpoints, or opinions on quality of life, were identified in the study. They were as follows:

- **Viewpoint 1:** Socially busy
- **Viewpoint 2:** Looking and feeling good
- **Viewpoint 3:** Accepting and feeling hopeful
- **Viewpoint 4:** Being independent
Figure 20-2 presents Viewpoint 1 in full detail, showing all of the statements along the continuum of least agreed (−4) to most agree (+4). All four viewpoints were represented using this format, in order to facilitate analysis and interpretation of the viewpoints.

**Viewpoint 1: Socially Busy**

This viewpoint suggested that quality of life meant having good social relationships and being able to pass time meaningfully (see Figure 20-2). By positioning statement 34 in the +4 (most agree) position, it could be considered that having the right to vote, being safe in their community, and having social access were important to participants. This viewpoint had a strong social trend. Placing statement 13 and statement 24 in the +3 position gave it a personal value that one needed to accept one’s self and pass personal time meaningfully. This suggested that being actively part of, and having an impact on, the community was vital, but having choice and freedom to pursue time as one wished was also essential for a good quality of life. Valuing material well-being and being sexually active did not relate to quality of life in this viewpoint. In addition, having pain and being disabled were not considered to have an impact on quality of life.

**Viewpoint 2: Looking and Feeling Good**

In this viewpoint, spiritual well-being and having personal dignity were considered important to quality of life (Table 20-2). There was strong agreement that quality of life depended on being independent and being physically pleasing. Being able to form relationships was also considered important. This suggested that the physical state was valued in order to be accepted socially and to maintain dignity. Similar to Viewpoint 1, this viewpoint suggests that material well-being and not being disabled did not contribute strongly to quality of life. This is contradictory to the value placed on being physically pleasing. In addition, spiritual well-being is not considered important as well as one’s perception of one’s health.

**Viewpoint 3: Accepting and Feeling Hopeful**

This viewpoint has a somewhat contradictory perspective in regard to the placement of certain statements (Table 20-3). Although good physical, mental, emotional, and psychological well-being was valued by the placement of statements 1 and 3, this viewpoint also valued the ability to accept one as is. The strong agreement of statement 8, however, emphasized the importance of being physically well. There was also a strong value placed on having expectations fulfilled and therefore demonstrating the importance of hope that all will go well. So, on one hand there was a hope that all will go well, and on the other hand it was recognized that if it did not, one needs to accept the situation. Similar to Viewpoints 1 and 2, material well-being and being young or physically pleasing were not considered important for quality of life.
Viewpoint 4: Being Independent

Having no pain and being in control of one’s activities of daily living were considered important in this viewpoint, as illustrated by the placement of statements 2 and 9 (Table 20–4). This suggested that having dominance over the physical world is important in order to have self-worth, which was valued in order to have a good quality of life (see placement of statement 14). Interestingly, no value was given to maintaining physical, mental, and psychological health. Being young and having intimacy was also not considered for a good quality of life in this viewpoint.

Table 20-2

<table>
<thead>
<tr>
<th>MOST LIKE/UNLIKE</th>
<th>NO.</th>
<th>STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>7</td>
<td>Quality of life is maintaining reasonable physical, emotional, and intellectual functioning.</td>
</tr>
<tr>
<td>+4</td>
<td>9</td>
<td>Quality of life is being able to eat, wash, and dress independently.</td>
</tr>
<tr>
<td>+3</td>
<td>22</td>
<td>Quality of life means having personal dignity.</td>
</tr>
<tr>
<td>+3</td>
<td>29</td>
<td>Quality of life is being able to form relationships with other people.</td>
</tr>
<tr>
<td>+3</td>
<td>36</td>
<td>Quality of life is being physically pleasing.</td>
</tr>
<tr>
<td>-3</td>
<td>4</td>
<td>Quality of life is not being disabled.</td>
</tr>
<tr>
<td>-3</td>
<td>5</td>
<td>Quality of life is when one has a good appetite and is able to sleep well.</td>
</tr>
<tr>
<td>-3</td>
<td>21</td>
<td>Quality of life is having spiritual well-being.</td>
</tr>
<tr>
<td>-4</td>
<td>19</td>
<td>Quality of life is the degree to which one has a positive appraisal and feelings about one’s life as a whole.</td>
</tr>
<tr>
<td>-4</td>
<td>33</td>
<td>Quality of life is having material well-being.</td>
</tr>
</tbody>
</table>

Table 20-3

<table>
<thead>
<tr>
<th>MOST LIKE/UNLIKE</th>
<th>NO.</th>
<th>STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>1</td>
<td>Quality of life means good physical and mental health.</td>
</tr>
<tr>
<td>+4</td>
<td>23</td>
<td>Quality of life is when one is able to accept oneself for who one is and accept one’s situation.</td>
</tr>
<tr>
<td>+3</td>
<td>3</td>
<td>Quality of life means physical and psychological and emotional well-being.</td>
</tr>
<tr>
<td>+3</td>
<td>8</td>
<td>Quality of life is being able to move freely and exercise.</td>
</tr>
<tr>
<td>+3</td>
<td>17</td>
<td>Quality of life is when your expectations of a good life are fulfilled.</td>
</tr>
<tr>
<td>-3</td>
<td>25</td>
<td>Quality of life is being able to work and earn money and feel productive.</td>
</tr>
<tr>
<td>-3</td>
<td>30</td>
<td>Quality of life is when one has intimacy and is sexually active.</td>
</tr>
<tr>
<td>-3</td>
<td>33</td>
<td>Quality of life is having material well-being.</td>
</tr>
<tr>
<td>-4</td>
<td>36</td>
<td>Quality of life is being physically pleasing.</td>
</tr>
<tr>
<td>-4</td>
<td>37</td>
<td>Quality of life is being young.</td>
</tr>
</tbody>
</table>
Chapter 20

Contribution to Occupational Science

This study offers to occupational science an enhanced understanding of quality of life as it is expressed through occupation. As such, it supports the value of the science across disciplines concerned with the study of quality of life, as well as contributing to the development of a central concept for the young science.

The literature suggests that there are many different definitions of quality of life (Kind, 2003), and the findings of this study support that. The four viewpoints that emerge represent different viewpoints from the perspectives of the individuals studied. It is interesting to note that all four viewpoints have both concrete and abstract elements in the expression of what is necessary for a good quality of life. Although all statements in the Q-sort were given equal potential, each viewpoint that emerged was on two levels and consistent with the way we proposed defining quality of life.

These results suggest that certain abstract values are needed for a good quality of life. For example, there needs to be certain “doing” elements. In Viewpoint 1, forming relationships and passing time meaningfully lead to self-acceptance, which is necessary for a good quality of life. In Viewpoint 2, independence and being physically pleasing lead to maintaining dignity. In Viewpoint 3, being in good physical, mental, and psychological health helps fulfill one’s aspirations and provides hope. In Viewpoint 4, independence and physical well-being lead to self-worth, which is important for a good quality of life.

The statements defining Viewpoint 1: Socially Busy suggest that this group values social access, contributing to society, and control beyond their personal sphere into their community. This viewpoint suggests that it is not enough to achieve basic capabilities and control daily routines. It is also important to maintain roles in society. Wilcock (1993) noted that, through doing, individuals can express their value and worth to society. This is consistent with Jackson et al.’s (1998) view that an important quality of an occupation is that it allows social connectedness. It also reflects that the element of control is an important issue for good quality of life, not just in daily routines but also in long-term commitments involving the wider community (Lau & McKenna, 2002). Reynolds (2003) considered the importance of a competent, able self involves both self-perception and the perceptions of others. Reciprocal relationships that encourage perceptions of value and competence, connecting, and belonging are also important (Hammell, 2004a; Laliberte Rudman et al., 1997; Reynolds, 2003).

Viewpoint 4: Being Independent implies that this group of participants value independence and being in control of their daily routines. This supports other literature that suggests that having choice and control over life is essential to quality of life. This is also consistent with Harvey’s (1993) theory that quality of life is closely related to daily routine. This is supported by the occupational therapy literature. The need to control one’s participation in occupation and to increase accessibility to an occupation is important for a good quality of life (Jackson et al., 1998). In addition, Christiansen (1994) suggested that having free choice contributes to meeting an individual’s intrinsic needs.

<table>
<thead>
<tr>
<th>MOST LIKE/UNLIKE</th>
<th>NO.</th>
<th>STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>1</td>
<td>Quality of life means good physical and mental health.</td>
</tr>
<tr>
<td>+4</td>
<td>4</td>
<td>Quality of life is not being disabled.</td>
</tr>
<tr>
<td>+3</td>
<td>2</td>
<td>Quality of life means the absence of pain.</td>
</tr>
<tr>
<td>+3</td>
<td>9</td>
<td>Quality of life is being able to eat, wash, and dress independently.</td>
</tr>
<tr>
<td>+3</td>
<td>14</td>
<td>Quality of life is having a sense of self-worth and feeling that life is worth living.</td>
</tr>
<tr>
<td>-3</td>
<td>3</td>
<td>Quality of life means physical and psychological and emotional well-being.</td>
</tr>
<tr>
<td>-3</td>
<td>5</td>
<td>Quality of life is when one has a good appetite and is able to sleep well.</td>
</tr>
<tr>
<td>-3</td>
<td>37</td>
<td>Quality of life is being young.</td>
</tr>
<tr>
<td>-4</td>
<td>30</td>
<td>Quality of life is when one has intimacy and is sexually active.</td>
</tr>
<tr>
<td>-4</td>
<td>7</td>
<td>Quality of life is maintaining reasonable physical, emotional, and intellectual functioning.</td>
</tr>
</tbody>
</table>
Do Rozario (1992) acknowledged that personal control and meaningful activity are coping viewpoints that facilitate health and well-being. This is also consistent with the Canadian Association of Occupational Therapists (1997), who stated that freedom of choice and control over one’s life are closely related to quality of life.

The concepts of Viewpoint 3: Accepting and Feeling Hopeful resonate with Felce’s (1997) definition of quality of life. Viewpoint 3 implies that faith, respect, resilience, and hope are important. These reflect two of do Rozario’s (1992) principles, the power of hope and the healing ability of spiritual experience. It recognizes that individuals aspire to new things. Believing in the potential to do or be something is consistent with Yuan’s (2001) description of a good quality of life.

The issue of self-worth in Viewpoint 4: Being Independent reflects how people gain a sense of control when choosing, shaping, and carrying out their daily occupations (Clark & Jackson, 1989). Qualitative research among people with physical impairments has identified five dimensions of experiencing and expressing meaning through doing. These include the need/opportunity to keep busy, have something to wake up for, explore new opportunities, envision future time engaged in valued activities, and contribute to others (Hammell, 1998, 2004a). These themes were characterized by the participants’ implied need for a sense of purpose and fulfillment. The ability to be able to execute daily occupations enabled individuals to increase their feelings of competence and fostered feelings of self-worth (Hammell, 2004a).

The four viewpoints emerging from this study illustrate how certain concepts that define quality of life are important to healthy Italian individuals. Qualitative research has shown that when people lose their ability to do those occupations that are important to them, this erases their perceptions of themselves as capable and competent, such that they describe feeling useless and valueless (Hammell, 1998; Reynolds, 2003). Conversely, researchers have observed a connection between engagement in personally valued occupations and perceptions of being competent, capable, and valuable (Hammell, 1998; Vrkljan & Miller Polgar, 2001). In the presence of an illness or disability there may be a shift in priorities and therefore further studies need to be carried out with people with different illnesses or disabilities to establish their perceptions. It cannot be assumed that everyone agrees that enabling choice, control, social connectedness, hope, and aspiration are important for a good quality of life and therefore further studies including establishing the viewpoints of service providers are necessary.

Implications for Practice

Occupational therapy is defined as “the profession concerned with promoting health and well-being through occupation” (World Federation of Occupational Therapists, 2010, p. 1). Occupational therapists are equipped with a broad spectrum of skills that allow them to work with those who experience barriers to participation (World Federation of Occupational Therapists, 2010). Occupational therapy “enables people to do the day-to-day activities that are important to them despite impairments, activity limitations, or participation restrictions or despite risks for these problems” (Moyers, 1999, p. 252). The occupational therapist is therefore responsible for treating the individual who has an increase in dependency due to disease, in order to maximize his or her participation in daily activities.

The findings of this Q methodology study suggest that occupational therapists need to be able to determine which aspects of occupation, as well as which occupations, are valued by their clients, in order to implement an intervention that will enhance quality of life. It supports arguments by Hammell (2004a) that forms of practice that are preoccupied with self-care, productivity, and leisure activities may be inadequate to address clients’ needs for meaning. Instead, occupational therapy is most relevant and useful when it addresses meaning, values, and purpose as these are experienced and expressed by clients through their chosen occupations. As Hammell stated, “Engagement in personally meaningful occupations contributes, not solely to perceptions of competence, capability and value, but also to the quality of life itself” (2004a, p. 303).

This Q methodology study can be a framework from which occupational therapists can work to determine specific occupational characteristics that are appropriate for every client. Establishing which viewpoint a client holds would assist the therapist to understand what concepts are important in order for that client to have a good quality of life. This could then provide guidance in the implementation of the intervention.

Learning Supports

Q Methodology

This simplifies the Q methodology process for beginners and uses the previous study as an example.

Introduction

- Developed in 1935 by British physicist-psychologist William Stephenson.
- Described as the science of subjectivity.
- Measures subjective views in a mathematical and rigorous fashion.
- Uses factor analysis (correlations)—individuals measure subjective opinions and those are then intercorrelated.
A combination of quantitative and qualitative measures of research.
This allows the researcher to explore everyday common language, concepts, and attitudes that are difficult to measure.
Allows for analysis of one statement in relation to other statements and not only the level of agreement as found in other forms of research.
The pack of statements is generated from the literature and then the participants will use these statements to perform the Q-sort.

Process of Q Methodology Using “Quality of Life” Example

1. Literature search process used for development of qualify of life statement pack. Can also conduct focus groups to develop statements (Table 20-5).
2. Development of statements for Q-sort (Table 20-6).
3. Examples of statements from quality of life study:
   - 2—“Quality of life means the absence of pain.”
   - 10—“A good quality of life means able to wash, dress, and eat independently.”
   - 14—“A good quality of life is having a sense of self-worth.”
   - 28—“A good quality of life is having your friends and family close to you.”
4. Data analysis: Can be done using free software from the World Wide Web called PQMethod (http://schmolck.userweb.mwn.de/qmethod/downpqwin.htm)
   - PQMethod generates factors for discussion.
   - Factors are common patterns that arise from the grids entered into the package.
   - The factors with the strongest weighting are accepted (usually two to four).
   - These will be represented as new grids.
   - The data will then be analyzed qualitatively; that is, a consensus of perceptions of this population group are explored.
5. Viewpoints (emerged factors) are qualitatively interpreted and discussed (see Watts & Stenner, 2012).

Connecting Results of the “Quality of Life” Study of Healthy Older Adults With the Characteristics of Occupation

This illustrates how Q methodology results can be applied to and inform practice.
1. Search for literature related to occupational therapy.
   - According to Jackson et al. (1998), there are four qualities to engaging in occupation. These can be linked to quality of life and are as follows:
     - Choice: Control of participation
     - Opportunity: Participation in new occupations
     - Access: Environmental changes to increase one's accessibility to occupations
     - Contact: Social connectedness through occupations
2. Link to results of study: Table 20-7 illustrates how the findings of the quality of life study have been mapped against Jackson et al.’s (1998) characteristics of occupation.

3. Reflection: Once a therapist understands what is valuable to his or her client, he or she can cater his or her intervention to that individual. Once a Q methodology study has been made and the various opinions have
emerged, the therapist can develop a questionnaire using the significant statements to understand where a person lies and which viewpoint represents him or her. If the therapist knows that his or her client is represented by Viewpoint (Factor) 1, he or she can choose occupations that give that person social access and contact. There are other occupational characteristics not described here (e.g., having a successful outcome). However, this characteristic for individuals represented by Viewpoint 1 is important because they need to be satisfied with themselves, so the therapist needs to take this into consideration. It is not just the case of choosing an activity that may interest the client but also that has a characteristic that satisfies his or her needs that renders it an occupation. Eating is an activity of daily living that can be completed as such or it can be done in a social context, which adds the characteristics of social contact. If the client then cooks for guests, it adds the characteristic of social contribution. The better the therapist knows his or her client group, the better he or she can organize his or her service to satisfy needs. Knowing the occupational characteristics can help overcome possible resource difficulties if the therapist does not have a variety of occupations to offer his or her client when looking at individual interests. It is important that the occupation chosen for the client has the characteristics necessary to have an impact on the well-being of the client and on his or her quality of life.

References


Quality of Life Research Unit, University of Toronto. (n.d.). Retrieved from http://www.utoronto.ca/qol/qol_model.htm


