

**THE SELECTED FACTORS RELATED TO QUALITY OF LIFE
OF ELDERLY PEOPLE IN BANGKOK**



**A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SCIENCE
(CLINICAL PSYCHOLOGY)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2008**

COPYRIGHT OF MAHIDOL UNIVERSITY

Thesis
Entitled

**THE SELECTED FACTORS RELATED TO QUALITY OF LIFE
OF ELDERLY PEOPLE IN BANGKOK**



..... Navamin Savirasarid

Mr. Navamin Savirasarid
Candidate

..... Sudsabay Chulakdabba

Assoc. Prof. Sudsabay Chulakdabba,
M.D., Dip (Psychiatry)
Major-Advisor

..... Gobhathai Sittironnarit

Ms. Gobhathai Sittironnarit,
M.D., Dip (Psychiatry)
Co-Advisor

..... B. Mahasavariya

Prof. Banchong Mahaisavariya,
M.D.
Dean
Faculty of Graduate Studies

..... S. Phattharayuttawat

Assoc. Prof. Sucheera Phattharayuttawat,
Ph.D. (Psychology)
Chair
Master of Science Programme in
Clinical Psychology
Faculty of Medicine, Siriraj Hospital

Thesis
Entitled

**THE SELECTED FACTORS RELATED TO QUALITY OF LIFE
OF ELDERLY PEOPLE IN BANGKOK**

was submitted to the Faculty of Graduate Studies, Mahidol University
for the degree of Master of Science (Clinical Psychology)

on
August 15, 2008

.....*Navamin Savirasarid*.....
Mr. Navamin Savirasarid
Candidate

.....*S. Phattharayuttawat*.....
Assoc. Prof. Sucheera Phattharayuttawat,
Ph.D. (Psychology)
Chair

.....*Sudsabuy Chulakdabba*.....
Assoc. Prof. Sudsabuy Chulakdabba,
M.D., Dip (Psychiatry)
Member

.....*Chaichana Nimnuan*.....
Asst. Prof. Chaichana Nimnuan,
Ph.D. (Psychiatry)
Member

.....*Gobhathai Sittironnarit*.....
Ms. Gobhathai Sittironnarit,
M.D., Dip (Psychiatry)
Member

.....*B. Mahaisavariya*.....
Prof. Banchong Mahaisavariya,
M.D.
Dean
Faculty of Graduate Studies
Mahidol University

.....*T. Kulthanan*.....
Clin. Prof. Teerawat Kulthanan,
M.D., F.I.M.S., F.R.C.S.T., F.I.C.S.
Dean
Faculty of Medicine, Siriraj Hospital
Mahidol University

ACKNOWLEDGEMENTS

The success of this thesis is made by possible by the supportive aid of numerous individuals. I would like to express my utmost gratitude and appreciation to my major advisor, Assoc. Prof. Sudsabuy Chulakdabba, who had guided and supervised me throughout the process of completing this thesis. I would also like to express my sincere appreciation and thankfulness to my co-advisor, Ajarn Gobhathai Sittironnarit, for sacrificing her valuable time and for giving many beneficial advices for this thesis, as well as Assoc. Prof. Sucheera Phattharayuttawat, Asst. Prof. Chaichana Nimnuan and Assoc. Prof. Chirdsak Kowasint for their helpful guidance and thoughtful recommendations.

I would like to extend my thanks and gratitude to the directors and officials of the Bangkok Medical Service Department and elderly groups under the care and supervision of the Bangkok Medical Service Department for their facilitation and cooperation of data collection. I would also like to express my sincere thankfulness to Ms. Parichart Chansri for giving valuable time for editing my thesis in English language.

Moreover, this thesis could not be completed if without a supporting scholarship from the Siriraj Graduate Thesis Scholarship, which allowed the research to be a success.

Finally, I would like to thank all my friends and colleagues for their sincerity, encouragements, genuine friendship and endless support. I am also thankful to Ms. Suphattra Chuenberkbarn for her friendly help and encouragement. Most importantly, nothing would have been possible without the understanding, supportiveness, and loving care from my family. My overwhelming gratitude for all of you could not be express into words.

Navamin Savirasarid

THE SELECTED FACTORS RELATED TO QUALITY OF LIFE OF ELDERLY PEOPLE IN BANGKOK

NAVAMIN SAVIRASARID 4936489 SICP/M

M.Sc. (CLINICAL PSYCHOLOGY)

THESIS ADVISORS: SUDSABUY CHULAKADABBA, M.D., Dip (PSYCHIATRY), GOBHATHAI SITTIRONNARIT, M.D., Dip (PSYCHIATRY)

ABSTRACT

This cross-sectional descriptive research aimed to examine the quality of life of elderly people. It identified selected factors related to a quality of life and demonstrated that there are predictable qualities that affect the quality of life of elderly people in Bangkok. The subjects were 388 elderly people who participated in the activities of elderly groups under the care and supervision of the Bangkok Medical Service Department. The research tools were a selected factors questionnaire and a Pictorial Thai Quality of Life (PTQL).

This study used descriptive statistics to analyze the selected factors, and then used a t-test, One Way Analysis of Variance and multiple correlation coefficient to analyze the selected factors that affect the quality of life of elderly people.

The study found that elderly people who participated in this study had high quality of life in terms of social function and self-esteem. However the physical, cognitive, affective, and economic aspects of their quality of life were mid-range.

The analytical results of this study indicated that elderly people's income and personal ailments were related to their quality of life. And sufficiency of income explained the variance in the quality of life of elderly people.

This study identified that participation in the activities of elderly groups probably helped to promote mental, physical well-being and quality of life for the elderly in Bangkok.

KEY WORDS : QUALITY OF LIFE / ELDERLY PEOPLE / BANGKOK

117 pp.

ปัจจัยคัดสรรที่เกี่ยวข้องกับคุณภาพชีวิตของผู้สูงอายุในกรุงเทพมหานคร
(THE SELECTED FACTORS RELATED TO QUALITY OF LIFE OF ELDERLY
PEOPLE IN BANGKOK)

นวมินทร์ สวีระสฤกษ์ 4936489 SICP/M

วท.ม. (จิตวิทยาคลินิก)

คณะกรรมการควบคุมวิทยานิพนธ์: สุศสบาย จุลกทัตพะ, พ.บ., อ.ว.(จิตเวชศาสตร์), กอบหทัย
สิทธิธรรณฤทธิ์, พ.บ., ว.ว.(จิตเวชศาสตร์)

บทคัดย่อ

การศึกษานี้เป็นการวิจัยเชิงพรรณนา ณ จุดใดจุดหนึ่งเพื่อศึกษาระดับคุณภาพชีวิต ปัจจัย
คัดสรรที่เกี่ยวข้องกับคุณภาพชีวิต และปัจจัยคัดสรรที่มีอำนาจในการทำนายคุณภาพชีวิตของ
ผู้สูงอายุในชมรมผู้สูงอายุกรุงเทพมหานคร โดยศึกษาในผู้สูงอายุที่มาร่วมกิจกรรมของชมรม
ผู้สูงอายุซึ่งอยู่ในความดูแลของสำนักงานการแพทย์ กรุงเทพมหานคร จำนวน 388 คน เครื่องมือที่ใช้
ในการวิจัยประกอบด้วย แบบสอบถามปัจจัยคัดสรรของผู้สูงอายุ และแบบประเมินคุณภาพชีวิต
ไทยแบบรูปภาพ (Pictorial Thai Quality of Life : PTQL)

การศึกษานี้ใช้สถิติเชิงพรรณนาในการวิเคราะห์ปัจจัยคัดสรรของผู้สูงอายุ และวิเคราะห์
ลักษณะปัจจัยคัดสรรของผู้สูงอายุกับคุณภาพชีวิตของผู้สูงอายุโดยใช้ t-test, One Way Analysis
of Variance และการวิเคราะห์สัมประสิทธิ์สหสัมพันธ์พหุคูณ (Multiple Correlation Coefficient)

ผลการศึกษาพบว่าผู้สูงอายุมีคุณภาพชีวิตด้านการปรับตัวทางสังคม และด้านความรู้สึกล
ภาคภูมิใจในตนเองอยู่ในระดับสูง ส่วนคุณภาพชีวิตด้านร่างกาย ด้านความนึกคิด ด้านอารมณ์
และด้านเศรษฐกิจอยู่ในระดับปานกลาง

ผลการวิเคราะห์ลักษณะปัจจัยคัดสรรของผู้สูงอายุกับคุณภาพชีวิตของผู้สูงอายุ พบว่า
ความเพียงพอของรายได้ โรคประจำตัวมีความเกี่ยวข้องกับคุณภาพชีวิตของผู้สูงอายุ และความ
เพียงพอของรายได้สามารถอธิบายความผันแปรของคุณภาพชีวิตของผู้สูงอายุได้ทุกด้าน

ผลการศึกษานี้ชี้ให้เห็นว่าการมาร่วมกิจกรรมของชมรมผู้สูงอายุน่าจะช่วยส่งเสริม
สุขภาพกาย สุขภาพจิต และคุณภาพชีวิตของผู้สูงอายุในกรุงเทพมหานคร

CONTENTS

	Page
ACKNOWLEDGEMENTS	iii
ENGLISH ABSTRACT	iv
THAI ABSTRACT	v
LIST OF TABLES	ix
LIST OF FIGURE	xi
CHAPTER	
I INTRODUCTION	
Background and Importance of the Problem	1
Research Objectives	4
Research Assumption	4
Limitation	5
Outcome and Benefits	6
Definition of Terms	6
II LITERATURE REVIEW	
Definitions, Concepts and Theories on the Elderly	
Definition of Elderly	10
Elderly Groupings	11
Elderly Changes	12
Elderly Theory	15
Elderly Needs	18

CONTENTS (Continued)

CHAPTER	Page
Definitions, Concepts and Theories on Quality of life	
Quality of life Concepts	20
Quality of life Definition	21
Quality of life Factors	22
Quality of life Assessment	25
Selected Factors Concepts related to Quality of Life	26
Related Research	29
III RESEARCH METHODOLOGY	
Characteristics of the Population and Sample Group	35
Research Tools	38
Data Collection	39
Duration of Data Collection	39
Statistical Analysis of the Data	39
IV RESEARCH RESULTS	
Research Results	41
V DISCUSSIONS, CONCLUSIONS, AND SUGGESTIONS	
Result Discussions	66
Research Conclusions	87
Suggestions from the Research Results	89
Suggestions for Future Research	91
Research Limitations	92

CONTENTS (Continued)

	Page
BIBLIOGRAPHY	94
APPENDIX	
Appendix A : Research Tools	108
Appendix B : Participant Information Sheet	112
Appendix C : Inform Consent	115
BIOGRAPHY	117

LIST OF TABLES

Tables	Page
1 The size of sample group in each elderly group under the care and supervision of the Bangkok Medical Service Department	37
2 The results of the PTQL are separated into three levels	38
3 Amount and sampler percentage sort by age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments	42
4 Amount and percentage of sample sorted by personal ailments	45
5 Average and standard deviation of the quality of life points in each domain	47
6 Comparing the average quality of life of sample group with difference in age	48
7 Comparing the average quality of life of sample group with difference in sex	49
8 Comparing the average quality of life of sample group with difference in marital status	50
9 Comparing the average quality of life of sample group with difference in level of education	51
10 Comparing the average quality of life of sample group with difference in sufficiency of income	52
11 Comparing the average quality of life of sample group with difference in family type	53
12 Comparing the average quality of life of sample group with difference in the right of ownership in the present residence	54
13 Comparing the average quality of life of sample group with difference in personal ailments	55

LIST OF TABLES (Continued)

Tables	Page
14 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the physical quality of life of elderly be the criteria	56
15 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the cognitive quality of life of elderly be the criteria	58
16 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the affective quality of life of elderly be the criteria	59
17 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the social function quality of life of elderly be the criteria	62
18 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the economic quality of life of elderly be the criteria	63
19 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the self-esteem quality of life of elderly be the criteria	64
20 Male and female members of elderly groups under the care and supervision of the Bangkok medical service department	93

LIST OF DIAGRAMS

Diagrams	Page
1 Six factors of the quality of life	24
2 Conceptual Framework	34



CHAPTER I

INTRODUCTION

Background and Importance of the Problem

Modern technological progress, especially in medical and public health sciences and services, which can better treat patients, and have significantly reduced the death rate. Between 1995-2000, the average male and female life expectancy was 67.36 and 71.74 respectively. Between 2000-2005 the average had increased to 68.15 and 72.39 years, with forecasts for 2005 to 2010 at 68.36 and 73 years of age (The Ministry of Public Health, 2006 [online]). The global age structure has changed with the expected growth of the elderly population from 10.0% in 2000 to 15.0% in 2525. More than half of the global population will be over 65, and will live in developing countries (Rattana Peathurai and Adul Viriyavetkul, 1995: 1). Thai elderly people are increasing at the same rate as the global population, will increase from 9.4% in 2000 to 20.0% in 2525, as a result of the Family Planning Policy of the National Economic and Social Development Board copy number 2. Thai children population (0-14 years old) will decrease from 24.7% in 2000 to 18.0% in 2525 (The Ministry of Information and Communication Technology, 2006 [online]). If the situation persists, Thailand will become an “Aging Population” (Jiraporn Katepitchwattana and Suvinee Vivatvanich, 2004: 5)

Due to the increasing growth of elderly people, many countries have paid more interest, and in 1999, the United Nations announced that that year is the Universal Year of the Elderly (Napaporn Chayowan, 1999: 54; Pravet Vasee, 2000: 9). The Thai government established the Board of National Elderly, from the Ministry Resolution Party on February 9, 1982. Additionally, the Research and Planning subcommittee of the National Elderly drafted the 20 year old charter (1982-2001) to be a master plan to establish an Elderly Development Organization whose objective is to carry out the Protect and Solve the Elderly Problem Policy, in order to improve quality of life of elderly people, which was passed on January 23, 1984. In accordance with this policy,

the Thai Elderly Council proposed that elderly groups be present at all communities. Elderly groups will set activities to encourage elderly health and be effective in the groups (Prapaporn Jinuntuya, 1993: 2), and serve as a central association for elderly people to share knowledge, develop themselves, mingle socially, and exercise to promote their happiness and prevent against mental disorders (Sompop Reungtrakul, 2005: 11).

Elderly people are living in the final stages of life, and are not excited by the so called “advanced age”, which is rapidly changing human processes, which will inevitably in death (Rungroj Poomriew, 2002: 4). This advanced age will affect humans in terms of physical, mental and social, (Bunlu Siripanich, 1992: 12-7), with organ and system deterioration, physical weakness leads to vulnerability to sickness. Mental changes are caused by three main factors, namely, the degeneration of the brain with age, abnormal psychology, and the social changes in terms of culture, economic, and technology in the environment of elderly people. In terms of social, elderly people are in a position in society that make them feel worthless, no matter how untrue this may be, for they have lose their work and income, resulting in them discrediting themselves. The advance age separates them from their friends and spouse, who gradually die off, leaving them to feel all alone, desolate and worried. They feel peevish, irritable, suspicious, confused and have difficulty sleeping, which is the main cause of mental illness amongst the elderly (Srithum Thanapoom, 1992: 114-5). These changes lead to health problems, which easily affect the elderly. Some elderly people reject change, because it is difficult for them to understand, and balance their mind with the environment, and if they can understand this problem they will be able to balance their lives, corresponding with Andrews & Roy (1991: 19-20). Understanding change leads to good health and well-being, and elderly can benefit from this.

Elderly people who have good quality of life as a result of living by the right principle, avoiding problems with themselves and others, and using the mind and reasoning to solve problems. Admitting in own value, own essential, self, other, social and environment decrease the living together in social contradict. Initiate the peaceful family & social, progress, stability, security, compact and in perfect order. (Nisarath Silapadet, 1996: 66-7)

Out of this concern, researches found that age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments are the main factors that affect quality of life of elderly people. Prapaporn Jinuntuya's research (1993) found that age, sex, marital status, level of education, family type and personal ailments are related, whereas Panistha Panichacheevakul's research (1994) found age, sex, marital status, level of education and sufficiency of income are related, and Sa-ing Chawarangkul (1995) who found that the factors that were related are objective and subjective factors, specifically, age, marital status, level of education and the right of ownership in the present residence.

The WHOQOL group of the World Health Organization remarked that quality of life has 6 domains (Sucheera Phattharayuttawat, 2005: 541 – 3) namely physical, psychological, level of independent, social relationships, environmental, and spirituality, religion and personal belief. These are similar to the factors in the Pictorial Thai Quality of Life (PTQL) questionnaire (developed by Sucheera Phattharayuttawat, Thienchai Ngamthipwatthana and Buncha Pitiyawanun, 2006 [online]), which includes the physical, cognitive, affective, social function, economic, and self-esteem.

This research intends to study the quality of life of elderly people in Bangkok, using the PTQL, since it meets Spitzer et al. (1987: 465-71) criterion for effective questionnaires, namely, 1.Short, easily understood and convenient to use. 2.Covers quality of life domains. 3.Consistent with the researching group. 4.Have sufficient questions. 5.Does not discriminate against age, sex, occupancy and diseases. 6.Have a test of confidentiality before use. 7.Approved by clinical experts. 8.Sensitivity on the group's health. 9.Clarify different subject group's quality of life. and 10.Reasonable. This tool is consistent with Thai society and easily understood clinically, and in the community (Sucheera Phattharayuttawat, 2005: 574-91) using appropriate language and pictures that suit elderly who have problems with literacy.

Research Objectives

1. To examine quality of life of elderly people in Bangkok elderly groups.
2. To identify the selected factors related to quality of life of elderly people in Bangkok elderly groups.
3. To demonstrate the predictable qualities of the selected factors that affect quality of life of elderly people in Bangkok elderly groups.

Research Assumption

1. Selected factors related to quality of life of elderly people include,
 - 1.1 Age is a selected factor related to quality of life of elderly people because it relates with past experiences. Elderly people have experiences in adjusting themselves and confronting problems. However, the advanced age affects health and quality of life because they must rely on others more, thus assuming that the younger elderly people have a better quality of life than the older.
 - 1.2 Sex is a selected factor related to quality of life of elderly people because it specifies the quality, power and human limitations of the individual, assigning social roles and duties, where males are more often respected and are leaders expected to hold important duties. Females are often assigned submissive roles as housewives, and are expected to respect the power of males. Quality of life assumes that male elderly people have better quality of life than the female elderly.
 - 1.3 Marital status is a selected factor related to quality of life of elderly people because it concerns matters of loneliness, in that there is someone to support them both in terms of physical and psychological, during sickness or health. Elderly people who are alone have nobody to depend on, thus assuming that elderly people with different marital status have different qualities of life.
 - 1.4 Level of education is a selected factor related to quality of life of elderly people, because it promotes knowledge and life experiences, enabling the better understanding of the world and life, to live suitably with decent occupations, incomes, values, and self-control, thus assuming that elderly people with higher education have better qualities of life than elderly people who have low education.

1.5 Sufficiency of incomes is a selected factor related to quality of life of elderly people because incomes pay for needs, such home, food, and medical expenses, thus assuming that elderly people with sufficient incomes have better qualities of life than those with insufficient incomes.

1.6 Family type is a selected factor related to quality of life of elderly people because families treat and tend to the elderly physically, psychologically, and socially, valuing the elderly, thus assuming that elderly people in extended families have better qualities of life than those in nuclear families.

1.7 The right of ownership in the present residence is a selected factor related to quality of life of elderly people, because rights to real estate is a guarantee of their happiness, whereas homes for the elderly have maintenance costs and other expenses, thus assuming that elderly people who hold different rights to ownership of their present residence have different qualities of life.

1.8 Personal ailments is a selected factor related to quality of life of elderly people, because worrying about personal ailments affects their psychology, assuming that elderly people without personal ailments have better qualities of life than those with personal ailments.

2. Selected factors, such as age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments can predict the quality of life of elderly people.

Limitation

This research focuses on elderly people over 60 years old participating in 9 elderly groups' activities under the control of the Bangkok Medical Service Department.

Outcome and Benefits

1. Acquire the selected factors related to quality of life of elderly people. In order to use these information as a basis to develop and plan a better quality of life for elderly people.
2. Obtain main and level of the quality of life of elderly people in Bangkok, to serve as a standard comparison of elderly quality of life.
3. The research results for the selected factors, main and level of the quality of life of elderly people in Bangkok can serve as a physical and psychological trend for healthcare services, to develop plans for a better quality of life for the elderly.

Definition of Terms

1. Elderly or elderly people refer to persons over the age of 60 participating in 9 elderly groups' activities, under the control of the Bangkok Medical Service Department.
2. The selected factors refer to the factors chosen by researcher consist of age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments.
 - 2.1 Age refers to the age of elderly people who are older than 60 years old from the year of birth.
 - 2.2 Sex refers to sex of elderly people that confine to male and female.
 - 2.3 Marital status refers to marital status of elderly people, is divided into three groups.
 - Single; no spouse.
 - Widowed, divorced, or separated, elderly people who used to live with their spouse but no longer living together now.
 - Married, lives with their spouse.

2.4 Level of education refers to elderly people's level of education, divide to four levels, namely, none, primary, secondary, and tertiary education.

2.5 Sufficiency of income refers to elderly people's monthly incomes, divided into two groups, namely,

- Sufficiency of income; can cover their expenses.
- Insufficiency of income; can not cover their expenses.

2.6 Family type refers to the group and structure of the elderly family, divided into two types, namely,

- Nuclear family referring to an elderly is
 - (1) Living alone or with a spouse.
 - (2) Living with children or relatives who have no family.
 - (3) Living with spouse and children.
 - (4) Living with relatives who have no family.
- Extended families refer to elderly people who live with a spouse, the family of children, and other relatives.

2.7 The right of ownership in the present residence refers to the elderly ownership of current residence, divided into four types namely, having sole ownership, shared ownership, relative-owned and other owners such as rented homes.

2.8 Personal ailments refers to status of health of the elderly, either having personal ailments or not.

3. Quality of life of elderly people refers to living at decent levels in terms of physical, psychological, affective, social and individual lives in society. Combining these perceptions in terms of physical, psychological, social relation, environment, culture, admiration, targeting 6 target components (Sucheera Phattharayuttawat, 2005: 526-591), namely

3.1 The physical quality of life of elderly people refers to the reception of sleep and rest, comfort, health body, bodily disorders, and strength to perform daily routines.

3.2 The cognitive quality of life of elderly people refers to the reception of thought, memory, concentration and decision making.

3.3 The affective quality of life of elderly people refers to the reception of anxiety, loneliness, weariness, panic, and sadness.

3.4 The social function quality of life of elderly people refers to the reception of working with others, ability to do routine work, interest in the surroundings, social activity, and social support.

3.5 The economic quality of life of elderly people refers to the reception of the financial status.

3.6 The self-esteem quality of life of elderly people refers to the reception of the confidence to think, pride in one's abilities, self-satisfaction, appreciation in successful work and self-valuation.

CHAPTER II

LITERATURE REVIEW

This research studies the selected factors related to quality of life of elderly people. Collected definitions, concepts, theories and related research are as follows

1. Definitions, Concepts and Theories on the Elderly
 - 1.1 Definition of Elderly
 - 1.2 Elderly Groupings
 - 1.3 Elderly Changes
 - 1.4 Elderly Theory
 - 1.5 Elderly Needs
2. Definitions, Concepts and Theories on Quality of life
 - 2.1 Quality of life Concepts
 - 2.2 Quality of life Definition
 - 2.3 Quality of life Factors
 - 2.4 Quality of life Assessment
3. Selected Factors Concepts related to Quality of Life
4. Related Research

1. Definitions, Concepts and Theories on the Elderly

1.1 Definition of Elderly

In elderly researches, it is first important to understand the meaning of being elderly, whereby aging is the process of continuous natural human physical declination and decreasing adaptability to the environment (Victors, 1999: 3 cited in Rungroj Poomriew, 2002: 4). Aging is divided into 2 types (Surakul Jenobrom, 1991: 2) as

1. Primary aging occurs to all humans naturally, and is unavoidable that organs and cells will deteriorate with age.
2. Secondary aging occurs when humans misuse the body with heavy work, inadequate rest, and lack of exercise, drunkenness, smoking, and continual fatigue.

Knowing the definition of aging, the following discusses the development of term “elderly” in Thailand. The term was first used by Major general Attasit Sittisoontorn in senior doctor and elderly people meeting on December 1, 1962, who defined it as the perceptions that are widespread in the present (Surakul Janobrom, 1991: 3 – 4). The term “elderly” refers to people who are living in the last part of their life. Originally, it was defined by social roles, which are often leadership roles, social responsibilities, but in the present this is more often defined by age differing from country to country, such as The United States of America defining it as 65, in Scandinavia, it was 67, which were the age of retirement. In Thailand, it is defined as 60 years of age, corresponding with the World Assembly on Aging in Vienna, Austria, which is the same standard used by most of the world (Rattana Peathurai and Adul Viriyavetkul, 1995: 1).

Gerontologists working on concepts of the elderly divided aging into four types (Surakul Jenobrom, 1991: 4-5), namely

1. Chronological aging by age
2. Biological aging perception of bodily changes by age such as white hair, wrinkles, farsightedness and baldness.

3. Psychological aging includes intellectual change such as loss of memory and decreased ability to learn.

4. Social aging includes family and friends as well as working responsibilities and social roles.

In summary, elderly people are individuals who are older than 60 years of age, living in the last part of life, where aging affects the body through its natural declination such as changes in intelligence, memory, learning, psychology and social roles.

1.2 Elderly Groupings

The elderly are divided by age, to make them easy to study and understand. Gerontologists use social psychology as rules to divide elderly people into 4 groups (Craig, 1991; Hoffman et al., 1988 cited in Sriruen Kaewkungwal, 2002: 541; Burnside et al. cited in Wantanee Kumpeang, 1997: 13), namely

1. The young-old, between 60-69 years old is the period of crisis, with retirement, death of relatives or spouse, decreasing incomes and loss of social status. Generally, people at this age have the strength, but rely on others and can still adapt to social situations, and is the period they are closest to young people, adapting through “engagement” of social activities both inside and outside the family.

2. The middle-aged old, between 70-79 years old, is a weak period, with friends and family dying, and reducing participation in social activities known as “disengagement”, and social engagement within and outside the family is minimal.

3. The old-old, between 80-89 years old, is the most difficult period, where the individual finds problems adapting to the environment, because it is more private and more stimulating, and they need more help from others, and live in a kind of nostalgia.

4. The very old-old of more than 90 years old. There are very few people living in this period, therefore the less available subjects for social biology and psychological research. They are very weak, and should carry out activities that are

non-competitive without time restrictions, but having passed this crisis they will live happily and peacefully.

Elderly people in every period have different physical, psychological and social changes, with health and social association on a decline through the affects of aging, affecting their quality of life.

1.3 Elderly Changes

Aging occurs naturally, and through time, passes through three important changes (Rungroj Poomriew, 2002: 10-2), namely

1. Physical Changes

The muscular and skeletal system: it was found that the muscles undergo dystrophy especially in the legs, where the contraction of the muscles are greatly reduced, starting from 30 years of age and increasing in speed at over 50 years of age. This dystrophy results in the lose of agility and balance. The bones also become more fragile, and the intervertebral disc becomes inflexible and loses its elasticity. The joints deteriorate with age, and are easily damaged resulting in accidents involved with movement.

The sensory system such as the eyes, ears, nose, tongue, and skin, for instance has reduced response times.

The skin loses its elasticity and fat stored beneath the skin, resulting in wrinkles, white spots, and freckles. The skin cells replicate itself slower, resulting in wounds healing slower. The sweat glands work less resulting in dry skin and itchiness, with hair loss and whitening.

The respiratory system: the lining of the heart thickens, with added cholesterol to the system resulting in the hardening of blood vessels, lacking elasticity. The movement of blood is slowed putting more burden on the heart, resulting in irregular heartbeats. Elderly people are also inflicted with light headedness, as a result of changes in movement that does not allow sufficient blood to the brain.

The nervous system: the brain and nerve cells are greatly reduced, especially after 60 years of age, by which the speed of deterioration is greatly increased, and due to this reduced number, the brain will swell, and parts of the brain will shrink such as the parts of the brain responsible for sight, the cerebellum, responsible for the coordination of various muscles, will be less efficient, resulting in slow movement, trembling, slow learning, problematic problem solving, and easy to forget present situations, but able to retain old information.

The digestive system: most elderly people have brittle teeth, with saliva glands excreting less saliva. The movement of the digestive track is slower, resulting in indigestion, and less absorption, putting elderly at risk of malnutrition.

The excretory system: the kidney deteriorates, resulting in its reduced ability to excrete waste. There is a need to urinate more as the bladder is unable to retain as much water as before. Some elderly people may experience difficulty in urinating, especially men who may have benign prostatic hypertrophy. Women have problem controlling their urinary sphincter, as a result of many labors.

The endocrine system: there is a reduced amount of ductless hormones, the pancreas produces less insulin increasing elderly people's chances of becoming diabetic than in other ages.

The immune system: is a body system that consists of numerous systems, working together to combat pathogens in the body. This system often malfunctions in elderly people.

2. Emotional and Psychological Changes

The emotional and psychological changes are the response of physical and social changes. The degeneration of organ systems and changes in the environment affect elderly people's emotion and psychology, as well as numerous affects of various kinds of loss such as.

2.1 Loss of loved ones, such as spouse, friends, relatives to death or moving to other places.

2.2 Loss of social and economic status, with retirement and the loss or decreased incomes, social relationships and job positions.

2.3 Loss of family relationships, with children moving away to get married, creating nuclear families instead of living together as an extended family, decreasing their role in consulting, care, and teaching, leaving them to live alone.

2.4 Loss of a sex life, affects elderly males, and is an important psychological problem.

3. Social Changes

Through aging, the body undergoes degeneration, making it weak and inefficient, and as a result must retire from work. Some elderly people used to hold high level duties, are heads of families, and have an income of their own to take care of themselves, but with aging they lose these things, and even their connections are lost. Social changes can be summarized as follows.

- (1) Decrease in roles and duties.
- (2) Change from taking care of other to relying on other to take care of them when they have grown weak and have lost their income.
- (3) Shrinking social networks as they lose their connection with friends and peers.
- (4) Ailments prevent them from joining in more social activities.
- (5) Loss of spouse and friends from death.

In summary, aging affects the elderly physically, making them weak and prone to sickness affecting their physical, affective, psychological, social changes and quality of life of elderly people.

1.4 Elderly Theory

Many fields of study are interested in the research of elderly, such as sociologists study related concepts of the elderly in cultures, biologists study the effects of cells in the elderly body, and doctors and public health studies elderly health, ailments and its protection and cure. Due to the variety of researches, there is an abundance of accumulated theories on the elderly, as presented in the following.

1. Theory of Social Psychology

There are many related social psychological theories concerning the elderly. As follows (Cockerham, 1982; Pherson and Barry, 1983)

1.1 Disengagement theory believes that most elderly people retreat from social engagements, in order to decrease social pressure, and give younger generations a chance to be representative, relaying things to the young as a sort of social balance.

1.2 Activity theory believes that elderly people are both physically and psychologically happy when participating in activities, and are more advantageous socially.

1.3 Continuity theory believes that elderly people are happy when they can continue to enjoy the same activities and social familiarity, however, prefer to be alone and may seclude themselves. The theory recognizes need to adapt with many social changes, such as death of a spouse, retirement and decreasing incomes.

1.4 Age stratification theory believes that social groups of the same age experience similar situations, so research must balance similar age groups with different ones.

1.5 Erikson's psychosocial theory believes that old age is the period of worthiness, firmness or dismay. Worthy elderly feel satisfied and content in leading a successful life, in peace and happiness, accepting death as a part of life. Conversely, dismayed elderly feel they are hopeless and refuse to live.

1.6 The Peck's development theory believed that early elderly period (55-75 years old) and the late elderly period (older than 75 years) have different characteristics and relation to psychology, which can be divided into 3 areas, specifically

1.6.1 Self-esteem and value depends on roles and duties, so that when they retire, they feel worthy.

1.6.2 Admitting that physical change is natural and try to adjust for a happier life.

1.6.3 Accepting physical change, they will not fear death.

2. Cross – Cultural Theory

Cowgill (1972) presented cross-cultural theory as social changes as a result of modernization is universal, but has variations following specific societies and cultures, such as

2.1 Social appearance is universal, and is present in all societies.

2.1.1 Elderly are socially a minority.

2.1.2 There are more female elderly than male elderly.

2.1.3 There are a larger number of widowed female elderly in society.

2.1.4 Elderly are socially treated differently as a group.

2.1.5 Elderly people often fill the role of counselors or responsible for managing tasks that are not physical in nature, and are often preoccupied with social roles more than economic production.

2.1.6 Elderly are often political or active leaders.

2.1.7 Mores are important determinants of the responsibility between the elderly and their children.

2.1.8 Society values elderly people, and seeks to find ways to prolong their elderly life.

2.2 Social appearance of elderly may change as societies undergo modernization.

2.2.1 Primitive societies age less than modern societies.

2.2.2 Determined by age in modern societies, but primitive societies tend to factor the state of being grandparents.

2.2.3 Statistically, longevity is a relative to level of modernization.

2.2.4 There are more elderly people in modern societies than there are in other societies.

2.2.5 There are more females widows than in other societies.

2.2.6 There are more grandfather and grandmothers than other societies.

2.2.7 In primitive societies, elderly hold high social power, but in modern societies their status is lower and unclear.

2.2.8 Elderly in primitive societies hold more important economic and political positions than modern societies.

2.2.9 Primitive societies, respect and worship ancestors.

2.2.10 Elderly hold more prestigious social role when there are few, but hold lower positions with high populations.

2.2.11 Increasing social change affects elderly status.

2.2.12 Stability of the house increases an elder persons' status, and the lack of stability of the house decreases their status.

2.2.13 Rural elderly population is more prestigious than their urban counterparts.

2.2.14 In preliterate societies, elderly hold high status, but the increasing level of education has lowered their status.

2.2.15 Elderly people, who contribute to the social good, remain in high status, but this is dependant on the popularity and ability to participate in activities.

2.2.16 Retirement is a new concept and is found in modern high productivity societies.

2.2.17 High status elderly people are often part of an extend family, whilst their lower status counterparts are part of nuclear or neolocal marriages.

2.2.18 Modern societies' response to management of economic stability of elderly people has shifted from family to government.

2.2.19 Elderly relationship in modern societies is lower.

2.2.20 In primitive societies, widowed female elderly inherits ascribed roles, but this is not so in modern societies.

2.2.21 Individualist values system in the East has decreased elderly status and stability.

2.2.22 In local societies, social deterioration and disengagement is not a prominent elderly characteristic, but disengagement increases with increased socialization and modernization.

In summary, the development and adaption of the elderly is dependent on many factors, theories, and activities, and modernization is consistent in all societies and cultures. These things let us understand the elderly more.

1.5 Elderly Needs

Elderly people have the same needs as other people, (Surakul Jenobrom, 1991: 89-90; Office of the Public Health Commission, 1988: 3-4) including

1. Economic needs. Elderly people need help economically, such as receiving support from their relatives. If elderly person has no income, government must provide welfare as a social security for aging, paying pension. Those with incomes can live happily, stably, and their decedents and society is safe from having to bear the responsibility.

2. Residential needs. Elderly people must have a residence, which they might live alone, or with their family or children, or living in public or private foster homes.

3. Health needs. Elderly people are weaker than young people so it is the responsibility of their families and children to take care of them. Many countries, such as The United States of America, and European countries, government takes elderly services seriously, with health security systems.

4. Work needs. Work is very important, because it not only provides an income, but let's elderly people spend time productively. Working prevents onset of boredom, for there are friends to share opinions and is a place to show one's abilities and earn respect. Some elderly people do not work for money, but just to spend time and few proud.

5. Family support needs. This includes love, respect, warmth, care from the family, which is very important to elderly people because death draws near. They want to be part of the family, accepted and respected. Despite non-relative or outside help, elderly still need love, closeness and respect from their descendants, to talk, to hug, to kiss, or dine with, praise and participate in activities together.

6. Participation in assembly needs. Elderly people want to be part of a group to develop their home town. Society should give them the opportunity to participate and learn new things to develop themselves.

7. Decreased dependence on others need. Family and society needs to encourage elderly people to join activities, enabling them to take care and be responsible for themselves and not society.

8. Social needs. Elderly people need to be part of a group and society, in order to be a person who is accepted, respected and seen as important by the group, assembly and society. They have a need to develop relationships with people in an assemble and society, adjusting themselves to the society.

These needs are important to elderly people because they affect their self-value and happiness. If these needs are satisfied, they will be happy and have good quality of life, if not they are prone to unhappiness, physical and psychological problems.

2. Definitions, Concepts and Theories on Quality of life

2.1 Quality of Life Concepts

Ideas concerning quality of life were established in the West in 1970s. Since then, quality of life and social concepts have become universal, albeit differing from cultures and societies (Sucheera Phattharayuttawat, 2005: 526), and difficult to define. Anuchad Puangsumlee and Oratai Arjum (1998: 38-42) explained that 1. Quality of life is a psychological process narrated and constructed by thoughts, filtered by different language, experiences, basis of education, presentation, and facts. 2. Quality of life is dependent on hidden values, which must be clearly defined to better evaluate methods and results, accepting and fixing concepts at the middle level of the same society. 3. These ideas build our understanding of human growth and development, long life, and psychological methods of each factor and values. This means that people regardless of age, social status or level of education are confronted by similar factors which are at times difficult to admit. (Romney and Brown, 1994 cited in Anuchad Puangsumlee and Oratai Arjum, 1998: 38)

For these reasons, the meaning of the quality of life is not universal and different characteristics of the cognitive may be similar but have more inter-dimensional factors. This means that there are similarities and differences, especially in terms of cognitive frame, understanding, and theoretical. However, Van Dam (1989 cited in Anuchad Puangsumlee and Oratai Arjum, 1998: 38-9) stated that no definition of quality of life is accepted unanimously, for there are many subjective issues such as physical, psychological, good living, sex, and routine.

Achara Navachinda and Kajeejaras Piromtumsiri, 1989: 6-18 stated that quality of life is divided into 2 concepts, specifically,

The first concept concerns personal feelings of person with good quality of life, and the reason that make them feel that way, which is the personal satisfaction to achieve one's own physical and psychological needs. Both physical and psychological needs are factors of the quality of life are the same basis of needs, but it is different

from Maslow's Hierarchy of Needs, meaning there is no standard to assess the level of satisfaction. According to this line of thinking, a humble villager may more satisfaction than a businessman because a businessman has desires and more success. Quality of life thus means the satisfaction with the state and environment they are living in which affects their needs, which is constantly changing.

The second thought concerns physical and environment, whereby quality of life is assessed by some external factors or through social relationships, which means that quality of life depends on good health and mind, according to environment and society.

In summary, quality of life is the satisfaction of physical, psychological, social and daily routines, which is constructed by experiences and the basis of education. Moreover, it considers differences in age, education, social class and values.

2.2 Quality of Life Definition

Quality of life is dependent upon time, place and personal perception through different life experiences, occupation, interests, education, tradition and culture etc. (Buntom Kijpreedaborisud and Somkid Issarawat, 1983: 158). Quality of life is a combination of two word, "quality" and "life" and as cited in the Royal Institute (1982: 187,269), "quality" is defined as good characteristics, personal characteristics or things, and "life" means living. Together it means good personal living, as well as other meanings.

Orem (1980) stated that quality of life and well-being are similar meaning personal satisfaction and happiness in life.

UNESCO (1993 cited in Sucheera Phattharayuttawat, 2005: 527) defined quality of life as the satisfaction of social and human needs.

The WHOQOL group (1994 cited in Sucheera Phattharayuttawat, 2005: 527) defined quality of life as a multidimensional concept that mixes personal perception in

terms of physical, psychology, level of freedom, independent of social relationships, environment and personal beliefs in terms of culture, values and personal life goals.

The Social Development Standard and Humanity Security Office (2005: 5) defined quality of life as human livelihoods and conditions that are the result of accumulated subjective and objective in a certain point of time.

Gunyarat Ubolwun (1997: 28) stated that quality of life is a satisfied perception level of a person indicated by their economic status, health, environment, lifestyle and participation in activities

Sasipat Yodpetch (1999: 104) defined the good quality of life of elderly people as having ability and productivity (Caro, Bass & Chen, 1993 cited in Sasipat Yodpetch, 1999: 104) able to live by themselves, using this ability creatively for themselves, their family, others and society.

Sucheera Phattharayuttawat (2005: 527) defined quality of life as the combination of the UNESCO and the WHOQOL group definitions, as a level of satisfaction in terms of physical, psychological, level of freedom, independent of social relationships, the environment, personal cultural beliefs, values and personal life goals.

In summary, quality of life refers to a level of personal satisfaction of life in terms of physical, cognitive, affective, social function, economic, and self-esteem depending on personal perceptions combined with culture, nurture, values and aims of life of each person.

2.3 Quality of Life Factors

There are many different factors that contribute to a good quality of life, according to individual and social perspectives.

UNESCO (1980: 312) stated that factors of the quality of life are related to health conditions, healthiness, nutrition, education, work, the environment, resources,

the location of residence, religion, popularity, morality and laws as well as psychological factors.

Haug and Folmar (1986: 332) stated that quality of life is a well-being indicator, and indicators include, physical health, sufficiency of income, having no conditional forces including support from family and friends. Factors that affect a state of living and quality of life factors are physical, affective, social, cognitive and psychological.

Flanagan (1978: 138-9) said that quality of life factors comes from five basic human needs, including,

1. Physical and material happiness. Physical happiness refers to being healthy and strong, free of ailments. Material happiness includes a house, good food, and other facilities.
2. Relationships with others such as spouse, parents, relatives, friends, and others. Children include as a kind of relationship.
3. Social and assembly activities to help others.
4. Developmental characteristics and success such as intellectual development, interest to learn, understand oneself, realizing one's disadvantage, working with interesting job, good income, and creativity.
5. Recreational activities such as reading, listening to music, sports, and other entertainment, being part of social activities.

Nipon Kuntsawee (1983: 85-7) stated that there are 6 factors of quality of life, which are the physical, affective, psychological, cognitive, physical environment and cultural environment.

Denham (1991: 48) stated that there are 5 factors of quality of life, specifically, physical environment, social relationship, physical health, mental health, personality and history of past characteristics.

Suceera Phattharayuttawat et al. (2006, [online]) fixed factors of the quality of life as divided into 6 factors, namely the physical, cognitive, affective, social function, economic and self-esteem.

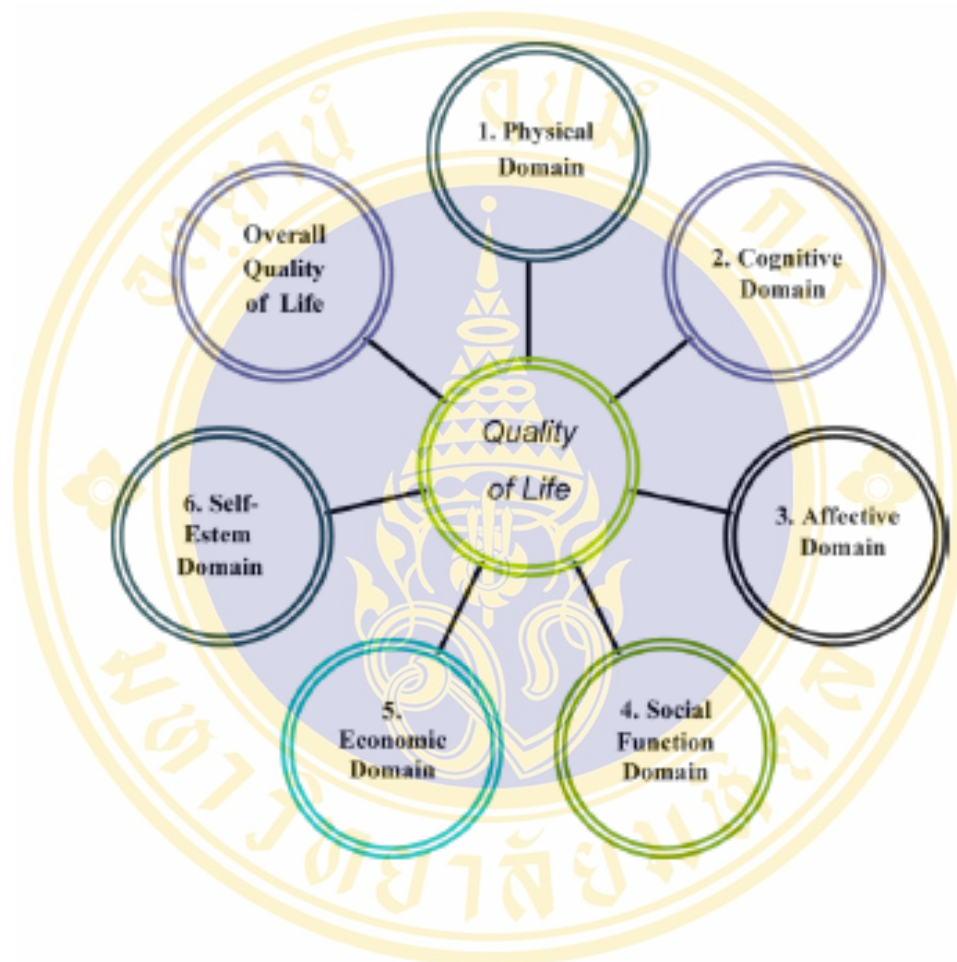


Diagram 1 Shows 6 factors of the quality of life (Suceera Phattharayuttawat, Thienchai Ngamthipwatthana and Buncha Pitiyawanun, (2006), [online]).

In summary, related factors of elderly quality of life are both tangible and intangible, depending on the individual and social cognitive. This study is a descriptive research to study the elderly quality of life in terms of physical, cognitive, affective, social function, economic and self-esteem.

2.4 Quality of Life Assessment

Quality of life assessment is separated by theory and research objective. The researches of quality of life assessment are as follows.

UNESCO (1980: 312) set 2 standards in the quality of life assessment as.

1. Objective scale of tangible data including economic, social and environmental data. etc.
2. Subjective assessment through psychological data in terms of affective, attitude towards individual experiences, perception of living conditions including everything related to life and satisfaction.

Stromberg (1984: 88-91) set 3 elderly quality of life assessment as following.

1. Objective Scale Yielding Quantitative Data assessed by others such as doctor or health team members to yield quantity points.
2. Subjective Scale Yielding Quantitative Data assessed by the elderly-self depending on their own definition of quality of life or their own experiences such as satisfaction, happiness, yielding quality points.
3. Subjective Scale Yielding Qualitative Data assessed by the elderly-self explanation of living status.

In summary, assessment of the elderly quality of life assesses both objective and subjective scale in terms of quantity and quality at that time.

3. Selected Factors Concepts related to Quality of Life

Many factors affect the elderly quality of life, but related research found that age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments affect elderly changes, elderly theory and elderly needs. It was found that

1. Age is related to past experiences. Elderly people with more experience have better personal adjustment to face with problems (Padilla & Grant, 1985 cited in Supat Teeravechcharoenchai, 2003: 66). Everything affects quality of life of the elderly, corresponding with Larson's research (1978: 113-4) and Tran, Chatter and Wright's (1991: 100) research. Aging affects physical degeneration, resulting in sickness and the reliance of others (Hanlon and Pickett, 1984: 433-4), hence younger elderly people have better quality of life than older elderly people. Edward, Klem and David (1973: 497-502) studied the elderly satisfaction of life in Virginia State, The United States of America, and found that younger elderly people are more satisfied and happy, thus having good personal quality of life, consistent with the study of Prapaporn Jinuntuya (1993), Panistha Panichacheevakul (1994), Wunna Gumajandra (2000) and Umpacha Panichchob (2003)'s research which found that younger elderly people have better quality of life than older elderly people.

2. Sex is a basic individual characteristic since birth, and is an indicator of quality, power and human ability, in terms of hereditary factors (Orem, 1980:220). Sex differentiates physical and social roles, often giving males the position of the family leader, with significant social roles, respected by females, who are often in the role of the housewife, obligating to respect male leadership. Spietz and Synder (1974: 456) studied elderly people in The United States of America and found that sex is related to elderly satisfaction of life, with males being more satisfied than females. This corresponds with the studies of Prapaporn Jinuntuya (1993) on elderly quality of life of the Din Daeng elderly group, Panistha Panichacheevakul (1994) on elderly quality of life of Northeastern Thailand, Wunna Gumajandra (2000) on elderly quality of life of Upper Southern Thailand and Umpacha Panichchob (2003) quality of life of the elderly in Bangkhae and private homes for the aged in Bangkok and boundaries.

3. Marital status is a factor that affects quality of life of elderly people. Elderly people who have a spouse to help and support them physically and psychologically in sickness and in health, to give them warmth, encouragement, wealth and values, giving them a better quality of life (Hubbard, et al. 1984: 266-9; Muhlenkamp and Sayles, 1986: 334-8), which is different from single elderly people who feel lonely and have no help. So marital status is related to quality of life of elderly people, corresponding with Robert's (1988: 10-1) research found that married elderly people have better quality of life than single elderly people, just like the research of Prapaporn Jinuntuya (1993) found that married elderly people have better quality of life than single elderly people including those who are widowed, divorced, or separated. Which corresponds with the research of Suwimol Panawattanakul (1991), Panistha Panichacheevakul (1994), Sa-ing Chawarangkul (1994) and Wantanee Kumpeang (1997)

4. Level of education. Education gives life experience, to know and understand how to live appropriately to give a better life and quality of living (Somchit Supharntut and Nipha Manuyapiju, 1992: 106). Level of education is related to occupation, income, values, self-concept and personal adaptability which affects quality of life (Brady, 1983: 11-26; Prapaporn Jinuntuya, 1993: 21). Sa-ing Chawarangkul's research (1994) found that level of education is related to the objective and subjective qualities of life, similar to the research of Suwimol Panawattanakul (1991), Gunyarat Ubolwun (1997), Wassana Tuenwongse (1997) and Aegarat Cheuinta (1997) found that level of education is related to the quality of life. The research of Prapaporn Jinuntuya found that elderly people who have a higher level of education will have better qualities of life than elderly people who have a lower level of education, consistent with the research of Panistha Panichacheevakul (1994) and Umpacha Panichchob (2003).

5. Sufficiency of income. Income is an important factor in the present living, because incomes enable the purchasing of needs such as house, foods and treats etc. So a higher income can purchase more things and alleviates the need to worry about income (Oren, 1991: 137); the higher the income, the better quality of life (Hogstel, 1981: 466). The research about quality of life of elderly people found that incomes are related to quality of life of elderly people (Panistha Panichacheevakul, 1994; Gunyarat

Ubolwun, 1997; Wantanee Kumpeang, 1997). And the research of Suwimol Panawattanakul (1991) and Zhan (1992: 795-800) found that elderly people with high incomes have higher quality of life than those with lower income. Although a higher income means a better quality of life, many different research deals with different levels of incomes, so in this research, the elderly are allowed to assess sufficiency of their income based on their personal opinions. If incomes are sufficient, their life would be happy, giving them a better quality of life.

6. Family type. Family is a basic social institution which is related to health of elderly, as families take care, respect and respond to the needs of the elderly in terms of physical, psychological and social making them feel valued, confident and balancing the affective and psychological, giving them satisfaction in life (Miller, et al., 1986: 205). Conversely, if a family does not take care of their elderly member, they may feel worthless, making them have risky behavior and problems with their health (Cohen and Wills, 1985: 310-57). These factors affect quality of life. The research of Tussanee Kreikultorn (1993) found that extended families caring for the physical and psychology of elderly are better than nuclear families, as well as the research of Prapraporn Jinuntuya (1993) which found that elderly people who stay with their families have better qualities of life than those who live alone.

7. The right of ownership in the present residence is elderly person's guarantee in real estate, so those living in their own house will be happier than living in another house, so the right of ownership in the residence affects their quality of life. Sa-ing Chawarangkul's (1994) research found that ownership in the house is related to the objective quality of life, and Umpacha Panichchob's (2003) research found that living in one's own house gives a good quality of life to elderly people. However, there are many maintenance expenses involved with the house (Yurick, et al., 1984: 157) so that the right of ownership in the present residence may be related to the elderly people's quality of life.

8. Personal ailments follow the Roy's adaptive theory (Andrew & Roy, 1991: 20) stated that quality of life is resulted by personal good health. Personal ailments are a factor that affects the elderly quality of life, because personal ailments are the cause of anxiety pertaining to the ailments and hence affecting their psychological state.

Therefore, quality of life of elderly with no personal ailments is better than those with personal ailments. Corresponding with Lauer (1982: 350) stated that personal ailments decrease quality of life, which is supported by the research of Prapaporn Jinuntuya (1993) and Umpacha Panichchob (2003) which found that elderly people with personal ailments have lower quality of life than elderly people with no personal ailments.

4. Related Research

In the present there are many pieces of research, focusing on elderly people both private and state-sponsored, the following are the related research concerning quality of life of elderly people.

Markides and Martin (1979) studied satisfaction of life of elderly people, and found that elderly people who are able to do routine work and confronts problems are more satisfied and happy.

Takahashi (1979) studied quality of life in Thailand by analyzing the economic and social factors and found 16 generalizing quality factors that are related, namely, overall quality of life, economics, religion, environment, community services, traffic accidents, reproduction, child labor, transportation, basic education, industry, death rate, crime, immigration of people, the elderly, and conditions of health. These factors can explain the variable of the quality of life at 87.70% and the best quality of life index is in Trad province (9.926%).

Ward et al. (1984) studied the relationship between social objectives supporting, namely, quantity and frequency of meeting with the children, neighbors and close-ones, receiving things, expression and social subjective support, namely, the sufficiency of subjective social support, and studying the relationship between subjective and the objective well-being of the social support of elderly people in New York, The United States of America, and found that quantity and frequency of meeting with the child, and sufficiency of meeting their child is positive statistically significantly related to elderly happiness.

Burckhardt (1985) studied effects of arthritis to quality of life of 27-98 year olds who were arthritis and found that the perception of social support, seeing their own value, control of the symptoms, and health conditions have positive correlations with quality of life.

Jumreang Kurmasuwan, Nittaya Pasunun and Venus Tuntibul (1989) studied the relationship between personal factors, ability to take care of oneself, and quality of life of elderly people who participate in 9 Bangkok elderly group's activities and found that happiness is highly related to satisfaction, happiness and satisfaction is related to the ability to accept of oneself and personal factors such as own assets, importance within the family, physical health, mental health, level of education and incomes. The ability to take care of oneself is related to personal factors, such as the level of education, incomes, own assets, mental health, sex, the importance within the family, and physical health. The variables that can predict quality of life in terms of happiness and satisfaction are of the same group, including mental health, own assets, ability to take care of themselves, and importance within the family, respectively, and quality of life in terms of happiness has more variables that can predict, which is level of education, and when all of them is analyzed, it can predict the quality of life in term of satisfaction and happiness at 61%.

Marasri Nuchseangplee (1989) studied quality of life of elderly people at the Bonkai community, Bangkok, and found that they are highly-moderately satisfied and the characteristics of their background such as marital status affect their satisfaction in life. The influential factor of the highest satisfaction in life is income, followed by health, level of education, frequency level of relationship with descendents, and habits, respectively. Non-influential factors include the elderly dependence level, working, relations with neighbors and close friendships.

Achara Navachinda and Kajeejaras Piromtumsiri (1991) studied the satisfaction standard variable of development of elderly quality of life to study factors related to quality of life of elderly, and found that urban and rural elderly people, who responded with high physical and psychological needs, have high level of satisfaction, which is related to the high level of quality of life. But elderly people in urban and rural, who have high level of psychological needs, have low level of satisfaction, and

their quality of life is also low. Elderly people who receive high psychological satisfaction will have better psychological health too. Many factors affect satisfaction of the physical and psychological needs of elderly people, thus it can be said that satisfaction itself is the variable in the quality of life of elderly people.

Prapaporn Jinuntuya (1993) studied elderly quality of life of the Din Daeng elderly group, to consider the factors of subjective quality that affect quality of life of elderly people, divided into 5 areas, namely economic status, health, the environment, self-dependency, and ability to do activities, and found that most elderly people had low quality of life (44.6%), moderate level (40%), and high level (15.4%).

Savitree Limchaiarunrung (1993) studied factors affected the perception of aging process and quality of life, through in depth interview at the Songkla Nurse College elderly group, and Hadyai hospital elderly group and found quality of life defined as “the elderly feel satisfied and happy with their physical, psychological health and social condition”. The overall quality of life of elderly people, albeit good or bad, high or low is dependent on their personal core satisfaction and feeling of happiness. Additionally, it was found that elderly people are aware of their quality of life and consider themselves as people with a good quality of life that, believing that they have a good life and are happy, at peace and are able to help themselves and others.

Sa-ing Chawarankul (1995) studied relationship between selected factors and quality of life of the elderly in Suratthani province and found that objective quality of life of elderly people is moderate at 53.1%, best at 46.9% and worst in terms of economic at 18.1%, family relationship, and psychological health at 13.5%. Subjective quality of life of elderly people is moderate at 45.3%, best at 40.9% and worst at 13.8%, which include ability to do routine work at 25.4% and psychological health at 23.6%. Objective quality of life is related to the selected factors of age, marital status, level of education, literacy main occupation, the right of ownership of residence, and people they are living with. Subjective quality is related to factors of age, marital status, level of education, literacy and main occupation. Objective and subjective qualities are also related.

Sujittra Nilleard (1996) studied family support and quality of life of the Thai rural elderly in Suphanburi province and found that the elderly's health and child's economic status correlates to child's support. Quality of the child's support of elderly people is moderated at 53.5% and 40.8% at high, and quality of life of elderly peoples is moderated at 65.1%, high at 22.8%, and if the support level is high, the quality of life is also high. The variable that can predict quality of life of elderly are respect, support in joining community or temple activities, income (money and things), acceptance of opinions, acceptance, and forgiveness for their shortcomings, and attention to talk. These variables are related to quality of life of elderly people and vary at 45.1%.

Gunyarat Ubolwun (1997) studied self-care behavior and quality of life of the elderly in central region, Thailand and found that quality of life of elderly people is mostly moderate, and basic factors related to quality of life of elderly people are sex, level of education, income, and boundary of the house.

Wantanee Kumpeang (1997) studied factors related to quality of life of rural elderly at Nakornratchasima province, and found that 69.1% of the subjects had a quality of life at a medium level. Quality of life in the high and low level were found in 16.8% and 14.1% of the subjects, respectively. There related factors of the elderly quality of life are age, marital status, occupation, income, elderly life-activity, health care service accessibility, and social support from neighbors. Through the application of the stepwise multiple regression, it was found that the quality of life of the rural elderly could be predicted by the level of elderly life-activity, health care service accessibility and income by approximately 29.84%.

Matsubayashi et al. (1997) studied quality of life of Japanese elderly people in the community, and found that the quality of life in terms of happiness, health, and life satisfaction were related to routine living.

Wunna Gumajandra (2000) studied quality of life of elderly people in Upper Southern Thailand, and found that quality of life of the urban and rural elderly people were moderate and not different statistically. Factors in term of age, sex, and family

income are statistically related to low quality of life. Religion and family lifestyle are factors not related to the quality of life.

Tidermark et al. (2002) studied the result of the femoral neck ailment relating to quality of life of elderly people, studying the relationship between quality of life score and the pain, suffering and daily life points and found that those with high pain scores have lower quality of life than those with lower pain scores.

Uenishi et al. (2003) studied quality of life of glaucoma elderly patients and found that their estimation of the severity of the ailment is related to quality of life and desponds statistically.

Umpacha Panichchob (2003) studied quality of life of the elderly at Bangkae home and private homes for the aged in Bangkok and boundaries, and found that a majority of the elderly at Bangkae home and private homes for the aged in Bangkok and boundaries were in a good level 48.8% and 73.8%, respectively. Related factors of a good quality of life are males, under 70 years of age, with a diploma educational level, a government official, before living in foster elderly house living with a spouse, lives in own house, good familiar relationships, before living in foster elderly house, is not addicted to drugs, healthy, and decide to get in by themselves. Marital status and reasoning to get in does not affect quality of life, and found that quality of life in terms of economic status, health, environment, depending on themselves and overall quality of life of elderly people in homes for the aged was better than those in Bangkae home for the aged. There were no activity differences. The satisfaction in the activities, and social relationships are related to the quality of life, but are not related to the satisfaction of services.

Repeated aspects in the related literature found that elderly people have changes in terms of physical, affective, psychological, and social, as well as specific needs in terms of economic, residential, health, work, family support, participation in community, decreasing the dependency on others and social. Both of changes and needs are effecting to elderly living. The selected factors are age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence, and personal ailments, which may be related to the quality of life of

elderly people in terms of physical, cognitive, affective, social function, economic, and self-esteem. For these reasons, the study of quality of life is worthy of attention, under the following conceptual framework.

Conceptual framework

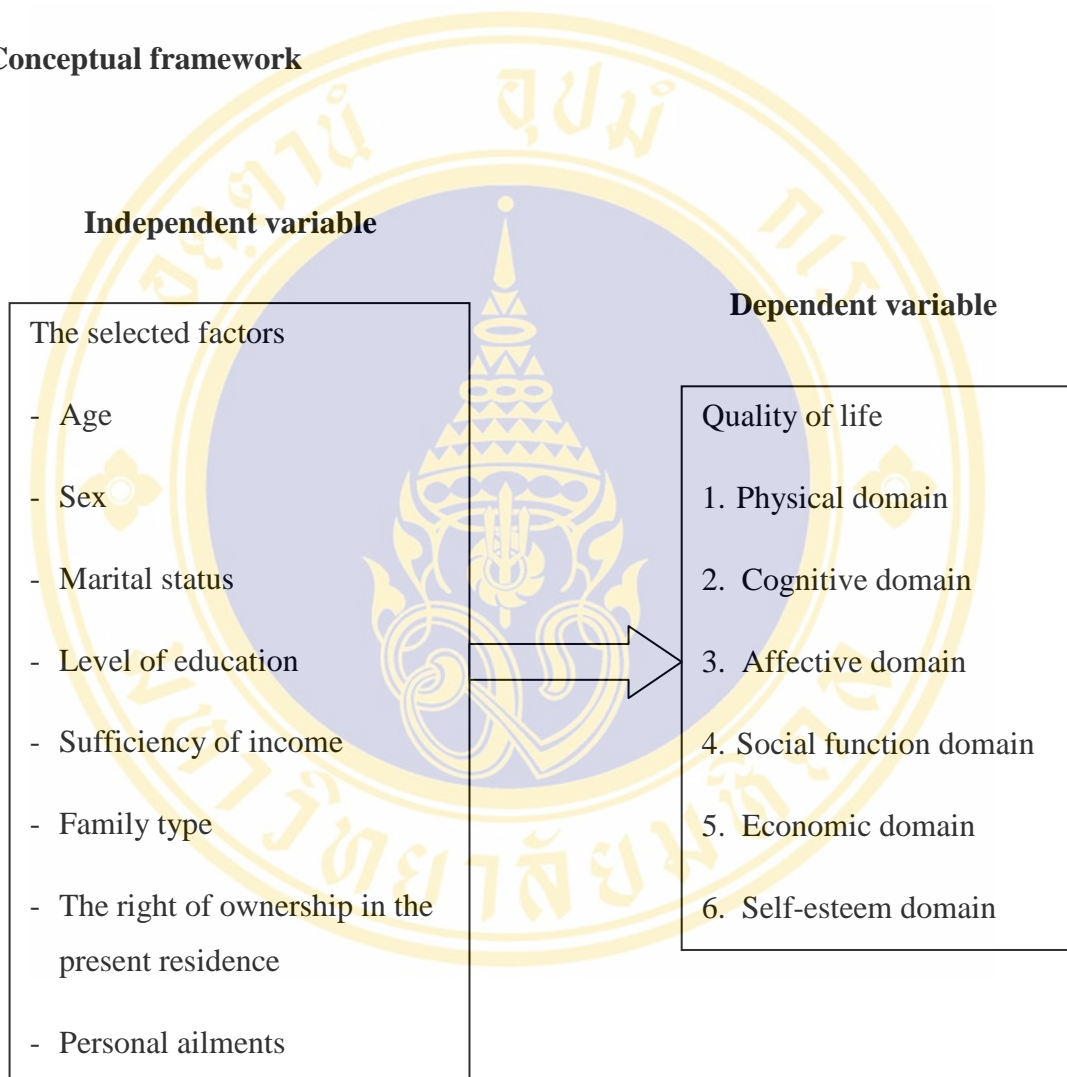


Diagram 2 Conceptual Framework

CHAPTER III

RESEARCH METHODOLOGY

This descriptive research aims to study the quality of life of elderly people, differentiated by age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments.

Characteristics of the Population and Sample Group

The population in this research is elderly people living in Bangkok, totaling 558,021 persons (December 2005) (The Ministry of Interior, 2006 [online]).

The size of the sample group in this study was calculated from a formula where the population size is known or predictable, but where the proportion of the population is unknown, due to previous researchers' findings that a large proportion of elderly people have mid-range standard of living, therefore the value for variance is given at .5 (Sucheera Phattharayuttawat, 2003: 63) as shown in the following.

$$n_{pm} = \frac{NZ^2}{4NE^2 + Z^2}$$

n_{pm} is the right population size in the estimated value P, in the case that variance is highest ($p=.5$) with reliability $(1-\alpha)$ where there are no deviation beyond E.

N is the total number of members from the designated population.

Z is value from the standard curve at the point where the area under the curve equals to $(\alpha/2)$, which the Z value limits the area under the standard curve at $(1-\alpha)$.

E is the size of the highest acceptable deviation, where the following was determined.

$$E = .05$$

Reliability at 95%; Z = 1.96

$$N = 558,021$$

As equated

$$\begin{aligned} n_{pm} &= \frac{(558,021) (1.96)^2}{4(558,021) (.05)^2 + (1.96)^2} \\ &= 388.0016 \\ &\approx 388 \end{aligned}$$

Therefore, in a population of 558,021 to have the acceptable 5% deviation and 95% reliability, a sample group of 388 persons must be used.

The sample group in this study are elderly people over the age of 60 who participates in the activities of elderly groups under the care and supervision of the Bangkok Medical Service Department, totaling 9 groups namely, Bangkok Metropolitan Administration (BMA) Medical College and Vajira Hospital elderly group, Bangkok Metropolitan Administration (BMA) General Hospital elderly group, Taksin Hospital elderly group, Charoenkrung Pracharak Hospital elderly group, Laung Pho Thawisak Jutindharo Hospital elderly group, Nong Chok Hospital elderly group, Bangkok Metropolitan Administration (BMA) Lat Krabang Hospital elderly group, Ratchaphiphat Hospital elderly group, Sirindhorn hospital elderly group (The Ministry of Social Development and Human Security, 2006 [online]).

The following assumptions are applied to the sample group used in this study

1. The elderly, both male and female, are 60 years or older
2. Are able to communicate in Thai. For those who are illiterate, the pictures will be shown the answers read aloud, and the answers will be recorded as such.
3. Are voluntary participants.

In selecting the sample group from the 9 elderly groups under the Bangkok Medical Service Department, which are of different sizes, the following formula was used

$$\text{The number of samples from each group} = \frac{\text{The wanted sample} \times \text{The group size}}{\text{The total number of elderly in all groups}}$$

Then through simple random sampling the calculated amount is selected, as seen in Table 1.

Table 1 The size of sample group in each elderly group under the care and supervision of the Bangkok Medical Service Department.

Elderly Group	Address	Total Members (Persons)	Size of Sample Group (Persons)
BMA Medical College and Vajira Hospital elderly group	681 Samsen rd., Dusit, Bangkok 10300	2,486	128
BMA General Hospital elderly group	514 Luang Rd., Pom Prap Sattru Phai, Bangkok 10100	995	52
Taksin Hospital elderly group	543 Somdejchaopraya Rd., Klongsarn, Bangkok 10600	840	44
Charoenkrung Pracharak Hospital elderly group	8 Charoenkrung Rd., Bangkhorlam, Bangkok 10120	1,009	52
Laung Pho Thawisak Jutindharo Hospital elderly group	39 Moo 4, Petchkasem Rd., Nhongkam, Bangkok 10160	152	8
Nong Chok Hospital elderly group	48 Moo 2, Luabvari Rd., Nongchok, Bangkok 10530	350	18
BMA Lat Krabang Hospital elderly group	190/15 Moo 1, Onnut-Ladkrabang Rd., Ladkrabang, Bangkok 10520	548	29
Ratchaphiphat Hospital elderly group	919 Moo 4, Buddhamonthon Sai 3 Rd., Bangkae, Bangkok 10160	452	24
Sirindhorn hospital elderly group	100 Moo 1 Onnut 90 Rd., Prawet, Bangkok 10250	643	33
Total		7,475	388

Research Tools

The tools used in this research's data collection consists of

1. Selected factors for the elderly which asks their demographic data, namely, age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments.

2. Quality of life test, of which the Pictorial Thai Quality of Life: PTQL was chosen. It was developed by Sucheera Phattharayuttawat, Thienchai Ngamthipwatthana and Buncha Pitiyawaranun, consisting of 25 questions in ordinal rating scales in 3 scales.

Scoring between the intervals of 0, 1, and 3

The PTQL separates quality of life into three levels (Sucheera Phattharayuttawat, 2005: 590-1) as follows.

Table 2 The results of the PTQL are separated into three levels as follows.

Quality of Life	Low Level	Middle Level	High Level
1. Physical Domain	0-4	5-10	11-15
2. Cognitive Domain	0-2	3-6	7-9
3. Affective Domain	0-4	5-10	11-15
4. Social Function Domain	0-3	4-8	9-12
5. Economic Domain	0-1	2-4	5-6
6. Self-Esteem Domain	0-4	5-10	11-15

The PTQL is consistent with the quality of life evaluation test used by the World Health Organization with a coefficient and ROC value of 0.92 and 0.97 respectively, an alpha impartiality of 0.88, with impartialities for 6 domains between 0.81 to 0.91 (Sucheera Phattharayuttawat, Thienchai Ngamthipwatthana and Buncha Pitiywaranun, 2006 [online]).

Data Collection

1. This research was approved from Siriraj Ethics Committee and the Bangkok Metropolitan Administration Ethics Committee for researches involving human subjects.

2. The researcher collects all the data, collecting and compiling the data according to specified dates, times, and venues as scheduled with the elderly groups. Data is collected as a group, whereby the researcher distributes the test and pens to the sample group, each person receiving one set, then explaining the procedure in answering the questionnaire. Then the groups are asked to respond without a time limit, during which the researcher will be nearby in order to assist the group, shall they have any questions.

3. Evaluate the basic data about the selected factors, checking scores for the PTQL of each sample.

4. Compile all the data into a computer for statistical analysis.

Duration of Data Collection

Data collection was carried out in 3 months, starting from December 4, 2007 to February 28, 2008.

Statistical Analysis of the Data

In this data analysis, the unit of analysis is the personal information of the elderly subjects, according to the following procedure.

1. Descriptive Statistics

This aims to study the selected factors for the elderly subjects, namely, age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments.

2. Analytical Statistics

This analyzes the selected factors of the elderly people with their quality of life.

2.1 Analyze the mean score variance of the quality of life and the selected factors that is separated into two types namely sex, sufficiency of income, family type, and personal ailments, using the t-test.

2.2 Analyze the mean score variance of the quality of life and the selected factors that is separated into three or more types namely age, marital status, level of education, and the right of ownership in the present residence, using the One Way Analysis of Variance.

2.3 Analyze the multiple correlative coefficient between all the variables, specifically the selected factors namely age, sex, martial status, level of education, sufficiency of income, family type, the right of ownership in the present residence, and personal ailments, with the criteria, which is the quality of life, using the stepwise multiple correlative coefficient, with the level of significance determined at .05.



CHAPTER IV

RESEARCH RESULTS

Research Results

This research aims to study the different qualities of life of elderly people in terms of age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence, and personal ailments. The sample group consists of elderly people older than 60 years of age participating in the activities of 9 elderly groups under the Bangkok Medical Service Department, which includes Bangkok Metropolitan Administration (BMA) Medical College and Vajira Hospital elderly group, Bangkok Metropolitan Administration (BMA) General Hospital elderly group, Taksin Hospital elderly group, Charoenkrung Pracharak Hospital elderly group, Laung Pho Thawisak Jutindharo Hospital elderly group, Nong Chok Hospital elderly group, Bangkok Metropolitan Administration (BMA) Lat Krabang Hospital elderly group, Ratchaphiphat Hospital elderly group, Sirindhorn hospital elderly group, totaling 388 persons. Data was collected in terms of a personal questionnaire and the Pictorial Thai Quality of Life: PTQL. The results are present in narrated tables in the following sections

Part 1 : Selected factors data of samples.

Part 2 : Quality of life data.

Part 3 : Selected factors concerning quality of life of elderly people.

Part 4 : The ability of the selected factors of quality of life of elderly people to predict the quality of life of elderly people.

Each section is as detailed in the following.

Part 1 : Selected factors data of samples.**Table 3** Amount and sampler percentage sort by age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments. (n=388)

Sample aspects	Amount	Percentage
Age		
• 60 – 69 years old	190	48.97
• 70 – 79 years old	163	42.01
• 80 – 89 years old	35	9.02
(Mean = 69.69, S.D. = 6.79, Min = 60, Max = 88)		
Sex		
• Male	84	21.65
• Female	304	78.35
Marital status		
• Single	47	12.11
• Widowed, divorced or separated	160	41.24
• Married	181	46.65

Table 3 Amount and sampler percentage sort by age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments. (n=388) (Continued)

Sample aspects	Amount	Percentage
Level of education		
• None	22	5.67
• Primary	139	35.82
• Secondary	108	27.84
• Tertiary	119	30.67
Incomes		
• < 5,000 baht	146	37.63
• 5,001 – 10,000 baht	110	28.35
• 10,001 – 15,000 baht	31	7.99
• 15,001 – 20,000 baht	52	13.40
• > 20,000 baht	49	12.63
(Mean = 11,260.84, S.D. = 10,716.21, Min = 0, Max = 100,000)		
Sufficiency of income		
• Sufficiency	299	77.06
• Insufficiency	89	22.94

Table 3 Amount and sampler percentage sort by age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments. (n=388) (Continued)

Sample aspects	Amount	Percentage
Family type		
• Nuclear family	236	60.82
• Extended family	152	39.18
The right of ownership in the present residence		
• Sole ownership	163	42.01
• Shared ownership	87	22.42
• Relative-owned	106	27.32
• Other owners such as rented homes	32	8.25
Personal ailments		
• Have	113	29.12
• No have	275	70.88

As shown in Table 3, it was found that most of the sample group are individuals in the 60-69 years old group (48.97%), followed by the 70-79 group (42.01%), with an average age of 69.69 years. Most are female (78.35%). Most are married (46.65%), followed by widowed, divorced or separated (41.24%). Most have primary school education (35.82%), followed by tertiary school education (30.67). Most have income below 5,000 Bath (37.63), followed by an income of between 5,001-10,000 Baht (28.35%), averaging 11,260.84 Baht. Most of the sample group felt that their income were sufficient to their expenses (77.06%), living in nuclear families

(60.82%), with the sole right of ownership in the present residence (42.01%) followed by those living with relatives (27.32%), and most have personal ailments (70.88%).

Table 4 Amount and percentage of sample sorted by personal ailments. (n=375)

Personal ailments	Amount	Percentage
Amount of personal ailments		
• 1 ailment	145	52.73
• 2 ailments	83	30.18
• More than 3 ailments	47	17.09
Personal ailments type*		
• Hypertension	137	49.82
• Hyperlipidemia	83	30.18
• Diabetes mellitus	54	19.64
• Orthopedic disease	53	19.27
• Cardiovascular disease	35	12.73
• Gouty arthritis	33	12.00
• Allergy	20	7.27
• Eye disease as glaucoma, cataract, macular degeneration etc.	9	3.27
• Peptic ulcer	5	1.82
• Cancer	5	1.82
• Asthma	4	1.45

Table 4 Amount and percentage of sample sorted by personal ailments. (n=375)
(Continued)

Personal ailments	Amount	Percentage
Personal ailments type* (continued)		
• Migraine	4	1.45
• Thyroid disease	4	1.45
• Sleep disorder as insomnia, sleep apnea syndrome etc.	3	1.09
• Gastroesophageal reflux disease	3	1.09
• Neuropathy	3	1.09
• Meniere' s disease	2	.73
• Sinusitis	2	.73
• Dementia	2	.73
• Hyperuricemia	2	.73
• Dermatosi s	1	.36
• Paresis	1	.36
• Kidney disease	1	.36
• Liver disease	1	.36
• Prostate disease	1	.36

(Note: *Some sample be more than an ailment.)

Table 4 shows that most of the sample group had one ailment (52.73%), followed by those who have two ailments (30.18%). The most personal ailment was hypertension (49.82%) followed by hyperlipidemia (30.18%).

Part 2 Relevant data to quality of life, in terms of mean, standard deviation, and the quality of life points in each domain.

Table 5 Average and standard deviation of the quality of life points in each domain. (n=388)

Quality of life	Mean	S.D.	Level of quality of life
Physical	9.60	3.45	Moderate
Cognitive	5.95	2.28	Moderate
Affective	10.40	3.93	Moderate
Social function	9.98	2.42	High
Economic	4.29	1.96	Moderate
Self-esteem	10.55	3.67	High

Table 5 shows that quality of life of the sample group in terms of social function and self-esteem is at a high level (Mean = 9.98, S.D. = 2.42; Mean = 10.55, S.D. = 3.67 respectively). In term of physical, cognitive, affective, and economic, they are only moderate (Mean = 9.60, S.D. = 3.45; Mean = 5.95, S.D. = 2.28; Mean = 10.40, S.D. = 3.93; Mean = 4.29, S.D. = 1.96 respectively).

Part 3 Selected factors related to quality of life of elderly people in each domain, compared with the sample group in terms of different age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence and personal ailments.

Table 6 Comparing the average quality of life of sample group with difference in age.

Quality of life	(1) 60-69 yrs. (n = 190)		(2) 70-79 yrs. (n = 163)		(3) 80-89 yrs. (n = 35)		F ^a	p-value
	Mean	S.D.	Mean	S.D.	Mean	S.D.		
Physical	9.53	3.59	9.60	3.37	9.94	3.14	.42 ^{NS}	.518
Cognitive	5.72	2.31	6.29	2.17	5.63	2.43	.04 ^{NS}	.834
Affective	9.67	3.96	11.16	3.73	10.83	4.04	2.63 ^{NS}	.106
Social function	9.68	2.60	10.33	2.20	10.03	2.26	.61 ^{NS}	.437
Economic	4.12	2.04	4.39	1.91	4.69	1.73	2.45 ^{NS}	.118
Self-esteem	10.51	3.66	10.75	3.61	9.86	4.02	.94 ^{NS}	.334

(Note: NS = Not Significant, *p<.05, **p<.01, ***p<.001,

^a Analyzed by One Way Analysis of Variance in Contrast Style.)

Table 6 shows that samples of different ages had no statistically different qualities of life in terms of physical, cognitive, affective, social function, economic, and self-esteem at .05.

Table 7 Comparing the average quality of life of sample group with difference in sex.

Quality of life	Male (n = 84)		Female (n = 304)		T	p-value
	Mean	S.D.	Mean	S.D.		
Physical	11.00	3.30	9.21	3.40	4.30***	.000
Cognitive	6.60	2.39	5.77	2.21	2.97**	.003
Affective	11.73	3.69	10.04	3.92	3.54***	.000
Social function	10.07	2.49	9.96	2.40	.37 ^{NS}	.711
Economic	4.10	1.89	4.34	1.98	-1.01 ^{NS}	.315
Self-esteem	11.49	3.74	10.29	3.62	2.66**	.008

(Note: NS = Not Significant, *p<.05, **p<.01, ***p<.001)

Table 7 found that members of the sample group with different sex had significantly different qualities of life in terms of physical, cognitive, affective and self-esteem at .05. Males have better qualities of life in terms of physical, cognitive, affective, and self-esteem than females. No significant difference was found for the qualities of life in terms of social function and economic between members of the sample group with different sex at .05.

Table 8 Comparing the average quality of life of sample group with difference in marital status.

Quality of life	(1) Single (n = 47)		(2) Widowed, divorced, or separated (n = 160)		(3) Married (n = 181)		F	p-value	Post-Hoc ^a
	Mean	S.D.	Mean	S.D.	Mean	S.D.			
Physical	8.60	3.33	9.13	3.41	10.28	3.40	7.20**	.001	1-3, 2-3
Cognitive	5.51	2.25	5.81	2.27	6.19	2.27	2.20 ^{NS}	.112	
Affective	8.87	3.75	9.78	3.93	11.35	3.76	11.51***	.000	1-3, 2-3
Social function	9.04	2.46	10.09	2.51	10.14	2.28	4.14*	.017	1-2, 1-3
Economic	4.47	2.07	3.99	2.06	4.50	1.82	3.19*	.042	2-3
Self-esteem	9.68	3.81	10.18	3.56	11.11	3.66	4.34*	.014	1-3, 2-3

(Note: NS = Not Significant, *p<.05, **p<.01, ***p<.001,

^a Testing the difference by Tukey HSD Method.)

Table 8 found that members of the sample group with different marital status had different qualities of life in terms of physical, affective, social function, economic and self-esteem at .05, and when testing these difference using the Tukey HSD, it was found that the qualities of life in terms of physical, affective, and self-esteem are significantly better in those that are married than those who are single, widowed, divorced or separated at .05. For the quality of life in terms of social function, members of the sample group that are married, widowed, divorced or separated have significantly better qualities of life than those who are single at .05. Those who are married have significantly better quality of life in terms of economic than those who are widowed, divorced or separated. No significant difference in the cognitive quality of life was found in the sample group with different marital status at .05.

Table 9 Comparing the average quality of life of sample group with difference in level of education.

Quality of life	(1) None (n = 22)		(2) Primary (n = 139)		(3) Secondary (n = 108)		(4) Tertiary (n = 119)		F ^a	p-value	Post-Hoc
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.			
Physical	10.50	3.08	9.80	3.66	9.17	3.47	9.59	3.24	1.90 ^{NS}	.169	
Cognitive	5.82	1.97	6.30	2.26	5.78	2.35	5.71	2.25	.27 ^{NS}	.603	
Affective	11.50	3.43	11.17	3.82	10.22	3.89	9.46	3.99	6.65*	.010	2-4 ^b
Social function	10.18	2.22	10.19	2.53	9.86	2.48	9.82	2.27	.70 ^{NS}	.404	
Economic	4.05	1.65	4.08	2.16	4.11	1.95	4.73	1.73	2.29 ^{NS}	.131	
Self-esteem	10.23	3.27	10.65	3.60	9.99	3.76	11.01	3.72	.42 ^{NS}	.516	

(Note: NS = Not Significant, *p<.05, **p<.01, ***p<.001,

^a Analyzed by One Way Analysis of Variance in Contrast Style.,

^b Testing the difference by Tukey HSD Method.)

Table 9 found that members of the sample group with different levels of education had significantly different qualities of life in terms of affective at .05, and when using the Tukey HSD found that the members of the sample group with primary education had significantly better quality of life than those with tertiary education at .05. No significant difference was found for the qualities of life in terms of physical, cognitive, social function, economic, and self-esteem amongst the members of the sample group with different levels of education, at .05.

Table 10 Comparing the average quality of life of sample group with difference in sufficiency of income.

Quality of life	Sufficient		Insufficient		T	p-value
	(n = 299)		(n = 89)			
	Mean	S.D.	Mean	S.D.		
Physical	10.12	3.31	7.84	3.35	5.68***	.000
Cognitive	6.20	2.23	5.11	2.25	4.03***	.000
Affective	10.90	3.76	8.74	4.05	4.66***	.000
Social function	10.19	2.29	9.29	2.70	2.85**	.005
Economic	4.99	1.46	1.92	1.56	17.17***	.000
Self-esteem	10.93	3.56	9.27	3.78	3.82***	.000

(Note: NS = Not Significant, *p<.05, **p<.01, ***p<.001)

Table 10 found that members of the sample group with differences in sufficiency of income had significantly different qualities of life in terms of physical, cognitive, affective, social function, economic, and self-esteem at .05, with member with sufficient incomes having significantly better qualities of life in terms of physical, cognitive, affective, social function, economic, and self-esteem than those that feel their income is insufficient.

Table 11 Comparing the average quality of life of sample group with difference in family type.

Quality of life	Nuclear (n = 236)		Extended (n = 152)		t	p-value
	Mean	S.D.	Mean	S.D.		
	Physical	9.39	3.31	9.91		
Cognitive	5.75	2.22	6.25	2.33	-2.11*	.036
Affective	9.95	4.01	11.10	3.70	-2.88**	.004
Social function	9.73	2.60	10.38	2.07	-2.70**	.007
Economic	4.24	1.95	4.36	1.99	-.56 ^{NS}	.578
Self-esteem	10.48	3.71	10.66	3.62	-.49 ^{NS}	.627

(Note: NS = Not Significant, *p<.05, **p<.01, ***p<.001)

Table 11 found that the members of the sample group with different family types had significantly different qualities of life in terms of cognitive, affective and social function at .05, with member who are part of extended families having significantly better qualities of life in terms of cognitive, affective, and social function, than members who are part of nuclear families. No significant difference was found between quality of life of those with different family types in terms of physical, economic, and self-esteem at .05.

Table 12 Comparing the average quality of life of sample group with difference in the right of ownership in the present residence.

Quality of life	(1) Sole (n = 163)		(2) Shared (n = 87)		(3) Relative- owned (n = 106)		(4) Other owners (n = 32)		F	p-value	Post-Hoc ^a
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.			
Physical	9.64	3.42	9.93	3.38	9.54	3.42	8.66	3.87	1.08 ^{NS}	.355	
Cognitive	5.96	2.22	5.92	2.39	6.10	2.22	5.47	2.44	.64 ^{NS}	.588	
Affective	10.22	4.11	10.80	4.03	10.42	3.68	10.16	3.61	.46 ^{NS}	.710	
Social function	9.98	2.61	9.85	2.33	10.29	2.10	9.38	2.62	1.34 ^{NS}	.260	
Economic	4.55	1.89	4.34	1.83	4.23	1.95	3.00	2.29	5.80 ^{**}	.001	1-4, 2-4, 3-4
Self-esteem	10.71	3.55	11.24	3.76	10.35	3.65	8.56	3.48	4.48 ^{**}	.004	1-4, 2-4

(Note: NS = Not Significant, *p<.05, **p<.01, ***p<.001,

^a Testing the difference by Tukey HSD Method.)

Table 12 found that members of the group with different rights of ownership of present residence had significantly different qualities of life in terms of economic and self-esteem at .05 and when tested with the Tukey HSD found that members with sole, shared or familial ownership to present residence had significantly better qualities of life than those where the ownership belongs to a third party at .05. In terms of self-esteem quality of life, it was found that members of the group with sole or shared ownership had significantly better quality of life than those whose ownership belonged to a third party at .05. No significant difference was found in the qualities of life in terms of physical, cognitive, affective, and social function between members of the group with different rights of ownership to their present residence at .05.

Table 13 Comparing the average quality of life of sample group with difference in personal ailments.

Quality of life	No have (n = 113)		Have (n = 275)		t	p-value
	Mean	S.D.	Mean	S.D.		
Physical	11.93	2.82	8.64	3.23	9.45***	.000
Cognitive	6.92	2.16	5.55	2.21	5.60***	.000
Affective	11.46	3.60	9.97	3.98	3.50**	.001
Social function	10.54	2.13	9.76	2.50	3.12**	.002
Economic	4.63	1.76	4.15	2.03	2.21*	.028
Self-esteem	11.34	3.49	10.23	3.70	2.72**	.007

(Note: *p<.05, **p<.01, ***p<.001)

Table 13 found that members of the group with differences in terms of personal ailments had significantly different qualities of life in terms of physical, cognitive, affective, social function, economic and self-esteem at .05, with members who had no personal ailments having better qualities of life in terms of physical, cognitive, affective, social function, economic, and self-esteem than those with personal ailments.

Part 4 The ability of the selected factors of quality of life of elderly people to predict quality of life of elderly people, including factors of age, sex, marital status, level of education, sufficiency of income, family type, the right of ownership in the present residence, and personal ailments.

Table 14 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the physical quality of life of elderly be the criteria.

Step no.	Selected factors	R	R ²	Beta	T	p-value
1	Personal ailments	.434	.188	-.434	-9.453***	.000
2	Personal ailments			-.414	-9.335***	.000
	Sufficiency of income	.498	.248	-.245	-5.519***	.000
3	Personal ailments			-.392	-8.958***	.000
	Sufficiency of income			-.254	-5.828***	.000
	Sex	.528	.279	-.178	-4.074***	.000
4	Personal ailments			-.389	-8.899***	.000
	Sufficiency of income			-.249	-5.729***	.000
	Sex			-.148	-3.224**	.001
	Marital status	.535	.286	.093	2.036*	.042
Constant = 27.671		Overall F = 38.430***				

(Note: *p<.05, **p<.01, ***p<.001)

Table 14 showed that in the first step of the stepwise analysis, the first predictor is personal ailments, because it is the most related to the physical quality of life at 18.8% (statistic significance at .001). In step two, the predictor is sufficiency of

income up to 24.8% (statistic significance at .001). Step three the predictor is sex, up to 27.9% (statistic significance at .001) and step four the predictor is marital status, up to 28.6% (statistic significance at .05), where the process ends because the remaining factors of age, level of education, family type, and the right of ownership in the present residence have no significant coefficient prediction.

The stepwise analysis revealed that the predictors that can predict quality of life of elderly people in terms of physical is personal ailments, sufficiency of income, sex, and marital status, which can jointly explain the variable physical quality of life of elderly people 28.6%, (statistic significance at .001).

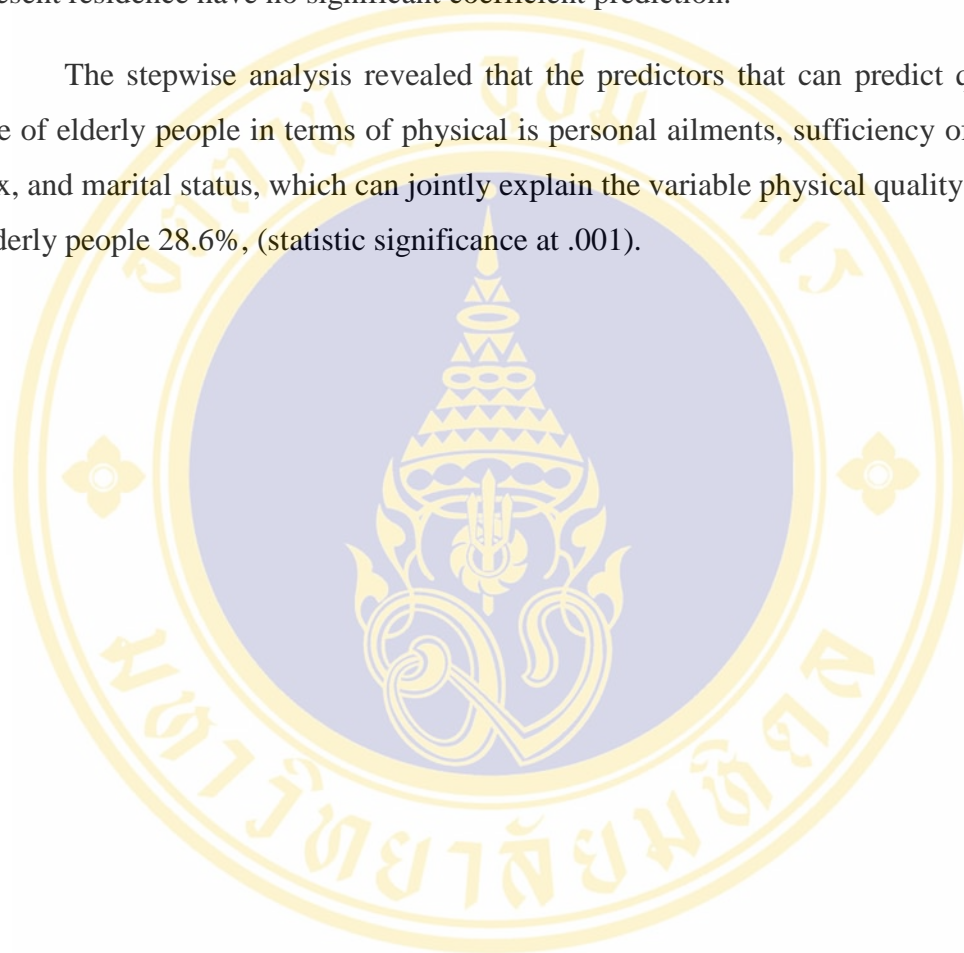


Table 15 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the cognitive quality of life of elderly be the criteria.

Step no.	Selected factors	R	R ²	Beta	T	p-value
1	Personal ailments	.274	.075	-.274	-5.602***	.000
2	Personal ailments			-.260	-5.379***	.000
	Sufficiency of income	.328	.107	-.180	-3.727***	.000
3	Personal ailments			-.244	-5.058***	.000
	Sufficiency of income			-.186	-3.886***	.000
	Sex	.352	.124	-.129	-2.668**	.008
4	Personal ailments			-.244	-5.089***	.000
	Sufficiency of income			-.184	-3.855***	.000
	Sex			-.131	-2.733**	.007
	Family type	.367	.135	.106	2.233*	.026
Constant = 25.452		Overall F = 14.929***				

(Note: *p<.05, **p<.01, ***p<.001)

Table 15 shows that step one of the stepwise analysis found that the first predictor is personal ailments, because it is the most related to the cognitive quality of life at 7.5% (statistic significance at .001). Step two the predictor is sufficiency of income up to 10.7% (statistic significance at .001). Step three is sex up to 12.4% (statistic significance at .01), and step four the predictor is family type up to 13.5% (statistic significance at .05), and ends at step four because the remaining factors of age, marital status, level of education, and the right of ownership in the present residence have no significant coefficient prediction.

The stepwise analysis revealed that the cognitive quality of life of elderly people can be significantly predicted by personal ailments, sufficiency of income, sex and family type. The four predictors can jointly explain the variable of the cognitive quality of life at 13.5% (statistic significance at .001).

Table 16 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the affective quality of life of elderly be the criteria.

Step no.	Selected factors	R	R ²	Beta	T	p-value
1	Sufficiency of income	.231	.053	-.231	-4.663***	.000
2	Sufficiency of income			-.222	-4.579***	.000
	Marital status	.317	.100	.217	4.490***	.000
3	Sufficiency of income			-.231	-4.886***	.000
	Marital status			.224	4.726***	.000
	Level of education	.378	.143	-.207	-4.381***	.000
4	Sufficiency of income			-.240	-5.114***	.000
	Marital status			.175	3.539***	.000
	Level of education			-.219	-4.662***	.000
	Sex	.404	.163	-.149	-3.008**	.003

Table 16 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the affective quality of life of elderly be the criteria. (Continued)

Step no.	Selected factors	R	R ²	Beta	T	p-value
5	Sufficiency of income			-.235	-5.046***	.000
	Marital status			.187	3.782***	.000
	Level of education			-.195	-4.085***	.000
	Sex			-.146	-2.964**	.003
	Family type	.420	.176	.118	2.484*	.013
6	Sufficiency of income			-.226	-4.847***	.000
	Marital status			.182	3.701***	.000
	Level of education			-.187	-3.935***	.000
	Sex			-.133	-2.704**	.007
	Family type			.120	2.530*	.012
	Personal ailments	.435	.189	-.115	-2.458*	.014

Table 16 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the affective quality of life of elderly be the criteria. (Continued)

Step no.	Selected factors	R	R ²	Beta	T	p-value
7	Sufficiency of income			-.216	-4.661***	.000
	Marital status			.193	3.930***	.000
	Level of education			-.176	-3.709***	.000
	Sex			-.108	-2.147*	.032
	Family type			.113	2.399*	.017
	Personal ailments			-.122	-2.617**	.009
	Age	.447	.200	.109	2.291*	.023
Constant = 11.919		Overall F = 13.593***				

(Note: *p<.05, **p<.01, ***p<.001)

Table 16 shows that step one of the stepwise analysis found that the first predictor is personal ailments because it is the most related to the affective quality of life at 5.3% (statistic significance at .001). Step two the predictor is marital status, up to 10.0% (statistic significance at .001). Step three the predictor is level of education, up to 14.3% (statistic significance at .001). Step four the predictor is sex, up to 16.3% (statistic significance at .01). Step five the predictor is family type, up to 17.6% (statistic significance at .05). Step six, the predictor is personal ailments, up to 18.9% (statistic significance at .05). Step seven, the predictor is age, up to 20.0% (statistic significance at .05). The remaining factor is the right of ownership in the present residence, which has no significant coefficient prediction.

The stepwise analysis revealed that affective quality of life of elderly people can be significantly predicted by sufficiency of income, marital status, level of

education, sex, family type, personal ailments and age. The seven predictors can jointly explain the variable of the affective quality of life of elderly people at 20.0% (statistic significance at .001).

Table 17 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the social function quality of life of elderly be the criteria.

Step no.	Selected factors	R	R ²	Beta	T	p-value
1	Sufficiency of income	.156	.024	-.156	-3.109**	.002
2	Sufficiency of income			-.145	-2.908**	.004
	Personal ailments	.207	.043	-.136	-2.712**	.007
3	Sufficiency of income			-.142	-2.868**	.004
	Personal ailments			-.136	-2.744**	.006
	Family Type	.242	.059	.127	2.560*	.011
Constant = 42.256		Overall F = 7.994***				

(Note: *p<.05, **p<.01, ***p<.001)

Table 17 showed that step one of the stepwise analysis found that the first predictor is sufficiency of income, because it is the most related to the social function quality of life at 2.4% (statistic significance at .01). Step two, the predictor is personal ailments, up to 4.3% (statistic significance at .01). Step three, the predictor is family type, up to 5.9% (statistic significance at .05). The remaining factors are age, sex, marital status, level of education and the right of ownership in the present residence, which has no significant coefficient prediction.

The stepwise analysis revealed that the social function quality of life of elderly people can be significantly predicted by sufficiency of income, personal ailments, and

family type. The three predictors can jointly explain the variable of the social function quality of life at 5.9% (statistic significance at .001).

Table 18 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the economic quality of life of elderly be the criteria.

Step no.	Selected factors	R	R ²	Beta	T	p-value
1	Sufficiency of income	.658	.433	-.658	-17.172***	.000
2	Sufficiency of income			-.648	-17.020***	.000
	The right of ownership in the present residence	.668	.446	-.114	-2.987**	.003
3	Sufficiency of income			-.645	-17.017***	.000
	The right of ownership in the present residence			-.100	-2.602*	.010
	Level of education	.673	.453	.082	2.150*	.032
Constant = 15.956		Overall F = 105.792***				

(Note: *p<.05, **p<.01, ***p<.001)

Table 18 show that step one of the stepwise analysis found the first the predictor to sufficiency of income, because it is the most related to the economic quality of life at 43.3% (statistic significance at .001). Step two, the predictor is the right of ownership in the present residence, up to 44.6% (statistic significance at .01). Step three, the predictor is level of education, up to 45.3% (statistic significance at .05). The remaining factors are age, sex, marital status, family type, and personal ailments, which have no significant coefficient prediction.

Stepwise analysis revealed that the economic quality of life can be significantly predicted by sufficiency of income, the right of ownership in the present residence, and level of education. The three predictors can jointly explain the variable of the economic quality of life of elderly people at 45.3% (statistic significance at .001).

Table 19 Analysis of the multiple correlative coefficient by used selected factors be the predicator and used the self-esteem quality of life of elderly be the criteria.

Step no.	Selected factors	R	R ²	Beta	T	p-value
1	Sufficiency of income	.191	.036	-.191	-3.818***	.000
2	Sufficiency of income			-.197	-3.967***	.000
	Sex	.238	.057	-.142	-2.872**	.004
3	Sufficiency of income			-.187	-3.788***	.000
	Sex			-.129	-2.603*	.010
	Personal ailments	.260	.068	-.107	-2.149*	.032
Constant = 26.624		Overall F = 9.310***				

(Note: *p<.05, **p<.01, ***p<.001)

Table 19 show that step one of the stepwise analysis found that the first predictor is sufficiency of income because it is the most related to the self-esteem quality of life at 3.6% (statistic significance at .001). Step two, the predictor is sex, up to 5.7% (statistic significance at .01). Step three, the predictor is personal ailments, up to 6.8% (statistic significance at .05). The remaining factors are sex, marital status, level of education, family type, and the right of ownership in the present residence, which as no significant coefficient prediction.

Stepwise analysis revealed that the self-esteem quality of life of elderly people can be significantly predicted by sufficiency of income, sex, and personal ailments, which can jointly explain the variable of the self-esteem of elderly people at 6.8% (statistic significance at .001).



CHAPTER V

DISCUSSIONS, CONCLUSIONS, AND SUGGESTIONS

Result Discussions

This study of the quality of life of elderly people consisted of a sample group of elderly people over the age of 60, who participates in the activities of 9 elderly groups under the care and supervision of Bangkok Medical Service Department which are Bangkok Metropolitan Administration (BMA) Medical College and Vajira Hospital elderly group, Bangkok Metropolitan Administration (BMA) General Hospital elderly group, Taksin Hospital elderly group, Charoenkrung Pracharak Hospital elderly group, Laung Pho Thawisak Jutindharo Hospital elderly group, Nong Chok Hospital elderly group, Bangkok Metropolitan Administration (BMA) Lat Krabang Hospital elderly group, Ratchaphiphat Hospital elderly group, Sirindhorn hospital elderly group, totaling 388 persons. The discussions of the findings are separated into the following sections.

1. The selected factors of the sample group.
2. Information about quality of life of the sample group.
3. Selected factors pertaining to quality of life of the elderly.
4. Selected factors that are able to indicate quality of life of the elderly.

Each section is as detailed in the following.

1. The Selected Factors of the Sample Group

The sample groups are elderly people who participates in the activities of 9 elderly groups under the care and supervision of Bangkok Medical Service Department. From Table 2, it can be seen that the largest group are elderly people between the ages of 60 to 69 (48.97%) most of whom are female (78.35%). When this is applied to crosstabulation analysis, it was found that 41.75% were female and 7.22% were male. Gerontologists say that this phase of old age is when the elderly are most likely the young in terms of their ability, and if they know how to adapt they will

often do so through “engagement”, that is they will participate in various social activities both inside and outside of the family (Craig, 1991; Hoffman et al., 1988 cited in Sriruen Kaewkungwal, 2002: 541; Burnside et al., cited in Wantanee Kumpeang, 1997: 13). The large number of female participates may be due to the fact that the elderly in this phase are still able of body and the male counterparts may be still working, but the females are interested in joining the activities and have more time to do so than their male counterparts, which can be seen from the results of the study which found that 46.65% were married, and therefore the female elderly may have husbands who are not interested in joining the activities, along with the longer average life expectancy of the female population. The Office of the National Economic and Social Development Board expects that between 2005-2010 the female population will have an average life expectancy of 73 years and the male population at 68.86 years (The Ministry of Public Health, 2006 [online]). The sample group also corresponds with Cowgill’s (1972) theory of cross-culture which states that fact there are more elderly females than there are elderly males is a common factors shared across all societies, therefore the sample group which has more women interested in health and participates in activities than men. From the factor of marital status it was found that 46.65% were married and 35.82% had only elementary school education, which was the mandatory level of education of Thailand at that time. When asked why they did not pursue higher education, the most common answer given was the onset of World War II, and following the war they did not return to school. In terms of income, most, 77.06% felt they had a sufficient income to their expenses, with an average income of 11,260.84 with most being nuclear families (60.82%), with the sole right of ownership to their present residence (42.01%). This shows that the sample group belongs to the group of people without any financial problems, as well as having rather decent financial and social standings, allowing them to participate in the various activities of the elderly groups. Additionally, in terms of health, most, 70.88%, have personal ailments, with 47.27% having more than two personal ailments, which corresponds to the survey on health and welfare in 2006 of the National Statistical Office which found that 50.50% of elderly people in Bangkok have a personal ailments (Foundation of Thai Gerontology Research and Development, 2007: 21), this is due to upon entering old age, the body undergoes a series of changes causing the

various systems in the body to perform below expectations or are confronted with problems, causing various illnesses. This can be seen from the same survey on health and welfare, which found that 31.10% of the elderly suffer from heart disease and other circulatory related maladies (Foundation of Thai Gerontology Research and Development, 2007: 23). This study found that 49.82% of the elderly subjects suffer from high blood pressure where heart disease ranked fifth in the study with 12.73% (Table 3). The high instances of high blood pressure in the group may be due to the fact that high blood pressure is the leading cause of heart disease and other circulatory related illnesses such as strokes, the lack of blood in the system, heart failure etc. (Yourhealthyguide, 2008, [online]), therefore it can be concluded that the group, for the most part, was in good health.

2. Information about Quality of Life of the Sample Group

Discussions of the results pertaining to the various facets of quality of life are as follows.

Physical It was found that quality of life of the sample group is in the mid-range, which the results of this study found that most the sample group had problems with their health, with 70.88% of the group having personal illnesses, and almost half (47.27%) had more than two personal illness. When a crosstabulation analysis was used, it was found that 57.73% of the female subjects had more illnesses than their male counterparts (13.14%), which corresponds with the study of Prapaporn Jinuntuya (1998: 77-8) who found that females often have more physical and mental problems than males, as well as often in old age there are many physical changes to the body's various systems causing them to perform below expectations causing various maladies. This supports the findings that survey on the quality of life in terms of physical is at the mid-range, showing that the sample group feels that their health is a serious problem because the sample participates in the activities of the elderly groups giving the opportunity to exercise under the close care and supervision of the Bangkok Medical Service Department's doctors and staffs. This corresponds with the study of Umnat Wangjin and Pimporn Fonglum (2003) who studied quality of life index of elderly people in Bangkok Umpacha Panichchob (2003) who studied quality of life of the elderly in Bangkhae home and private homes for the aged in Bangkok and

Boundaries, and found that elderly people have physical quality of life at the mid-range.

Cognitive It was found that quality of life of the sample group is in the mid range, due to the sample group being over 60 years old, where the results found that the average age of the subjects was 69.69 years, which is the phase when the body undergoes a serious of physical changes which affect perception, memory, concentration, and decision-making in the elderly such as the degradation of brain and nerve cells causing difficulty in learning new things, solving problems, and forget short term memories easily (Rungroj Poomriew, 2002: 10-2). Nevertheless, participating in the activities of the elderly groups help to compensate the results of these aforementioned physical changes, because the sample group gets to exchange and converse and learn new things and ideas about the current situation, allowing these elderly people to develop themselves, as well as help to stimulate their thoughts. Due to the physical changes and various degradation of the body, there are activities that help to stimulate the body, making possible for the sample group to have mid-range quality of life.

Affective It was found that quality of life of the sample group is in the mid-range, which should be explainable from the study which found that most of the sample group, 60.82%, are nuclear families, which Rungroj Poomriew (2002: 11) stated that nuclear families are often subjected to the loss of capacity within the family, due to the children leaving the family to start families of their own, reducing the role of the elderly in term of giving advice, care, and teaching the family. This corresponds with the cross-culture theory of Cowgill (1972) which states that the elderly have tendency to have reduce capacities in societies that favor nuclear families and neolocal marriage, which leaves the elderly in a position of being alone, causing them to feel lonely. Additionally, in old age there are often emotional changes as a result of physical and social changes such as sickness, loss of loved ones, loss of social and economic status (Rungroj Poomriew, 2002: 11). These things affect the emotions of the elderly negatively. However the results of the affective quality of life found that the sample group has a mid-range quality of life, may be due to the stimulation and care from the activities and the other members of the group participating in the

activities as the activity theory believes that participating in activities give the elderly happiness both physically and emotionally (Cockerham, 1982; Pherson and Barry, 1983). Therefore, the sample group has a mid-range affective quality of life, even though much of the sample group comes from nuclear families.

Social function It was found that quality of life of the sample group was high, which shows that group evaluates themselves as capable of adapting to society, because in participating in the elderly group activities, they are trained to adapt to other people, as gerontologists suggest that the elderly should adapt themselves by joining various social activities or what is called “engagement” (Craig, 1991; Hoffman et al., 1988 cited in Sriruen Kaewkungwal, 2002, 541; Burnside et al. cited in Wantanee Kumpeang, 1997: 13) because doing so they are addressing the need to socialize and live with others in a community and meeting the social needs of the elderly, building good relationships with others in society and the community and able to adapt socially (Surakul Jenobrom, 1991: 90; Office of the Public Health Commission, 1988: 4). Additionally, participating in the activities of the elderly groups also help the elderly to build up their physical and mental health, making them content with life, and accept various changes that have occurred. These things are all components that help the elderly adapt to various things (Sukchoke Singhagunt, 2007: 107-10). This corresponds with the activities theory, which believes that elderly people who participates in activities are able to adapt physically, emotionally, and socially (Barrow & Smith, 1979: 53), and for this reason, the sample group feels they have a high quality of life in terms of social function.

Economic It was found that quality of life of the sample group was at mid-range, where the results of the study found that the sample group had an average income of 11,260.84 Baht, with 62.37% earning more than 5,000 Baht, and 77.06% feeling that their income is sufficient for their expenses. Nevertheless, the elderly still want economic stimulation (Surakul Jenobrom, 1991: 89-90; Office of the Public Health Commission, 1988; 3-4) because most of the group are retired, reducing their net income, but where their expenses are still maintained or have increased due additional burdens from medical and health expenses. The study found that much of the sample group, 60.82%, are from nuclear families and are the sole owners of the

right to their current home of residence (42.01%) giving them the burden of various expenses in the family, such as home maintenance (Yurick, et al., 1984; 157) along with the other aforementioned reasons. This results in the elderly in the sample group feeling that they have a mid-range quality of life in terms of economics, which corresponds with the study of Aegarar Cheuinta (1997) who studied quality of life of elderly people in Northern Thailand, and Umpacha Panichchob (2003) who studied quality of life of elderly people in welfare home for the elderly Bangkhae and other private homes for the elderly in Bangkok and the metropolitan area.

Self-Esteem It was found that quality of life of the sample group was high, from the results of the study, it was found that the group had an average income of 11,260.84 Baht, with 62.37% earning more than 5,000 Baht, and 77.06% feeling that their income is sufficient for their expenses, along with the group being the sole owner of the rights to the home of their residence (42.01%). From this information, most elderly people feel proud and see themselves positively. Additionally, in participating in the activities of the elderly groups, they feel physically and emotionally happy, because they participate in activities and get to move their bodies, causing them to live their social lives happily and purposefully (Cockerham, 1982; Pherson and Barry, 1983). This corresponds with Kochakorn Sanghchart (1993: 33), who stated that having social activities causes the feeling of satisfaction in life, enabling people to see a goal and value life. For this reason, the group has a high quality of life in terms of self-esteem.

3. Selected Factors Pertaining to Quality of Life of the Elderly

The discussion for the selected factors that affect quality of life are separated according to the following assumptions.

Assumption 1.1 Younger elderly people have a better quality of life than the older.

The results of the study does not correspond with the assumption, and found that different sample groups have qualities of life in terms of physical, cognitive, affective, social function, economic, and self-esteem, that are not statistically significantly different at .05, which shows that perceptions about the physical,

cognitive, affective, social function, economic, and self-esteem does not change with age. This may be due to the selection process of the staff responsible for admitting new members into the elderly groups so they are of sound health and are interested in their health therefore participating in the activities of the elderly groups. Most of the activities of the group are exercise, such as aerobics, ballroom dancing, etc. The groups also organize training about taking care of one's health on a monthly basis, allowing the elderly to learn and understand about taking care of themselves correctly allowing them to see the changes that occur and are able to accept these changes. The fact that the sample group are elderly people meaning that they have experience, allowing them to confront problems, make decisions, and solve problems or accept things, enabling them to adapt. Additionally, being the elderly they have a somewhat stable income such as pension, money from their children, interests, and most elderly people do not have environmental changes around them, and do not have to carry the burden from the expectations of society, resulting in differing ages within the group having similar qualities of life in terms of physical, cognitive, affective, social function, economic, and self-esteem, which is different from the study of Wantanee Kumpeang (1997) who studied the quality of life of elderly people in the rural areas of Nakornratchasima and Wunna Gumajandra (2000) who studied quality of life of elderly people in the upper parts of Southern Thailand and found that age is negatively correlated with a statistically significance ($r=-.2478$, $p\text{-value}<.001$; $r= -.325$, $p\text{-value}<.05$, respectively), that is younger elderly people have higher qualities of life than older elderly people, may be because the sample group have different characteristics, in terms of region of residence, and participation in activities of elderly groups, therefore the studies do not correspond.

Assumption 1.2 Male elderly people have better quality of life than the female elderly.

The results of the study which corresponds with assumption 1.2 found that members of the sample group with difference sex have different qualities of life in terms of physical, cognitive, affective, and self-esteem, at .05, where the males were found to have higher qualities of life than their female counterparts. From the results of this study, it was found that 70.88% of the sample group have personal ailments and

in this number almost half (47.27%) had more than two personal ailments. Using a crossstabulation analysis found that female subjects (57.73%) had more personal ailments than their male counterparts (13.14%), which corresponds with the study of Prapaporn Jinuntuya (1993: 77-8) who stated that female often have more physical and emotional problems than males, as well as the survey on health and welfare 2006 by the National Statistical Office, which found that the female elderly had more personal ailments than their male counterparts (53.3% and 41.4% respectively) (Foundation of Thai Gerontology Research and Development, 2007: 23). Additionally, the fact that Thai society trains males to be leaders and expecting men to express their leadership in a group, putting them in the position to make decisions, giving the value to respect for men as the head of the family, making males receive praise and recognition both in the family and in society, along with limitations for females resulting in their dependency on men (Hanlon and Pickett, 1984). Females often consider the various factors in detail, and pay more attention to their emotions and feelings than males, and when there are problems, females often obsess over the problem causing worry and anxiety or boredom or despair from the situation. For this reason, the male subjects have better qualities of life in terms of physical, cognitive, emotional, and self-esteem, than their female counterparts, which corresponds with the study of Spietz and Synder (1974: 456) who studied elderly people in the United States and found that sex is related to the contentment of the elderly, whereby males are more satisfied with their life than females. The study of Prapaporn Jinuntuya (1993), Panistha Panichacheevakul (1994) Gunyarat Ubolwun (1997) Wunna Gumajandra (2000) and Umpacha Panichchob (2003) found that male elderly have better quality life than their female counterparts.

Results that do not correspond with assumption 1.2 found that members of the group with different sex have qualities of life in terms of social function and economic that are not statistically significantly different at .05, which shows that social function and economic of the elderly in the study does not change with sex. This may be due to the rather stable income of both male and female subjects due to their retirement, and having no additional burden of expenses, as well as participating in group activities stimulating their various needs, such as economic needs, health needs, social needs etc. (Surakul Jenobrom, 1989: 89-90; Office of the Public Health Commission, 1988 : 3-4).

For these initial reasons, subjects with different sexes have qualities of life in terms of social function and economic that are not different.

Assumption 1.3 Elderly people with different marital status have different qualities of life.

Results of the study that correspond with assumption 1.3 found that member of the group with different marital status have qualities of life in terms of physical, affective, social function, economic and self-esteem that are different, with a statistical significance of .05 and when testing the differences in the quality of life scores in terms of physical, affective, and self-esteem as a pair using the Tukey HSD found that married subjects had better qualities of life than their single counterparts, and widowed, divorced, or separated couples with a statistical significance of .05. This may be due to in having a spouse, they feel that they need to take care of their health and help to take care of one another. This corresponds with the study of Umaporn Udomsupayakul (1993: 67) who found that elderly people who are married are often more involved in activities than elderly people who are single. Additionally, marriage also serves as a kind of friendship that can offer help, counsel, encouragement, making one feel warm not lonely or lost, and have emotional stability (Prapaporn Jinuntuya, 1993: 81). Along with having a spouse, elderly people show the mature mental and social development, resulting in self-esteem, as well as give a sense of stability to the family in terms of physical, affective, and self-esteem, therefore member of the sample group who are married have qualities of life in terms of physical, affective, and self-esteem that is higher than members who are single, widowed, divorced, or separated. As for the quality of life in terms of social function, when doing a comparison in pairs using the Tukey HSD, found that members of the sample group who were married or were widowed, divorced and separated had better social function than members who were single with a statistical significance of .05. This may be due to a life with a spouse will give the individual the experience in being close with another person, enabling them adapt or try to adapt before they have come to old age, giving them better skills than their single counterparts, who lack the experience. This gives the members who are married, widowed, divorced or separated, a better quality of life in terms of social function than those who are single who lack the experience of being

close with another person. In terms of economic quality of life, when testing the difference using the Tukey HSD, it was found that members who are married had a better quality of life than member who were widowed, divorced or separated, with a statistical significance of .05, which may be due to in having a spouse an individual feels they have someone to depend on or ask for counsel, consistently helping or in helping a spouse and family, being the giver and receiver of both physical and emotional encouragement, as well as economic and financial support, giving a sense of warmth, determination, giving them stability in their life and a sense of self-worth, improving their quality of life (Hubbard, et al. 1984: 266-9; Muhlenkamp and Sayles, 1986: 334-8). However, losing a spouse will cause the elderly person to feel they have no one to depend on or seek counsel, physical and emotional, as well as economic and financial, giving members who are married a better economic quality of life than member of the sample group who are widowed, divorced or separated. This study corresponds with the study of Prapaporn Jinuntuya (1993) and Wantanee Kumpeang (1997) who found that elderly people who are married have better quality of life than elderly people who are single and corresponds with the study of Sa-ing Chawarangkul (1995) Wassana Tuenwongse (1998) and Aegarar Cheuinta (1998) who found that marriage is relate to quality of life, that is elderly people who are married have better quality of life than their single counterparts.

Results of the study that did not corresponds with assumption 1.3 found that there were no significant difference between members of the sample group that were married and those who were not with a value of .05 in terms of cognitive quality of life, showing that cognitive perceptions does not change with difference in marital status, which may be due to the theory of cognitive development of Piaget, who stated that cognition is the result of various learning experiences, accumulated since childhood, until their own cognitive map is created (Sirichai Hongnguan Sri, 2005: 13), along with the most of the elderly people who are educated (94.33%) has received education since elementary giving them knowledge, able to understand the world and various aspects of life, enabling them to lead appropriate and quality lives in society, because education organizes life experiences (Somchit Supharntut and Nipha Manuyapiju, 1982: 106). Old age is also a period when they have accumulated life experiences,

enabling them to confront various problems, able to make good decisions. Therefore, members of the sample group who are married have qualities of life than those who are not married.

Assumption 1.4 Elderly people with higher education have better qualities of life than elderly people who have low education.

Results of the study that do not correspond with assumption 1.4 found that members of the sample group with different levels of education have different affective qualities of life at .05, and when the differences are tested using the Tukey HSD method, it was found that member of the sample group with education at the elementary levels had better affective qualities of life than members with higher than primary education at .05 significance. This may be due to individuals with higher education often do not listen to the opinions of other and have high expectations in life (Wunthida Imsutjai, 1997: 95) forcing them to find information to consider details before making decisions and taking action, and solving problems through direct confrontation, which may cause them to feel anxiety when they are unable to solve problems. Those with less education have more concrete thinking, and practical expectations in life, willing to listen to others, and in confronting problems, often do not obsess over the issues, therefore members of the sample group with elementary education have better affective qualities of life than groups with more than primary education. This is different from the study of Prapaporn Jinuntuya (1993), Panistha Panichacheevakul (1994) and Umpacha Panichchob (2003) who found that elderly people with higher education had better qualities of life than those with lower education, which may be due to difference in the characteristics of the sample group, wherein Prapaporn Jinuntuya's study specifically elderly people in the elderly groups in Din Daeng which is an urban area, Panistha Panichacheevakul and Umpacha Panichchob's studies were different in terms of place of residence, character of residence, and participation in the activities of the elderly groups, causing differences in affective perception.

As for the quality of life in terms of physical, cognitive, social function, economic and self-esteem, it was found that different levels of education did not affect the quality of life significantly at .05, which shows that the perceptions of the elderly

in terms of physical, cognitive, social function, economic and self-esteem does not change with education. This may be due to changing social factors; therefore education in the past does not have an effect on thoughts pertaining to cognition, social function, economic and self-esteem. Elderly people are able to understand and take advantage of medical facilities such as state hospitals, public health units, equally, along with their life experiences, hence often using their experiences to help make decisions. Additionally, in participating in the activities of the elderly groups, they receive knowledge about health and participate in social activities of the members who are of similar ages, affecting their daily routines, interests and social encouragement. 77.06% of the group feel their income is sufficient to their expenses, and often elderly people do not have to carry the extra burden of expected expenses. For these reasons, members with different levels of education showed no differences in terms of their quality of life in terms of physical, cognitive, social function, economic and self-esteem.

Assumption 1.5 Elderly people with sufficient incomes have better qualities of life than those with insufficient incomes.

Results of the study that correspond with assumption 1.5 found that members of the sample group with differences in terms of sufficiency of income have significantly different qualities of life in terms of physical, cognitive, affective, social function, economic, and self-esteem at .05, where the group with sufficient incomes had better qualities of life than those with insufficient incomes. This may be due to the importance of the factor of income in addressing the physical, emotional, and social needs, along with a society that is highly consumerist, which stimulates the need to consume endlessly, causing those with high incomes or who feel their income is sufficient to their expenses to be able to meet their needs better than those with insufficient incomes to feel anxiety concerning their own financial situation (Orem, 1991: 137), hence those with high or sufficient incomes are often happy, content with their life and have high qualities of life (Hogstel, 1981 : 466). Therefore, the sample group that feels their income is sufficient have better qualities of life in terms of physical, cognitive, affective, social function, economic and self-esteem than the members with insufficient incomes. This corresponds with the study of Panistha

Panichacheevakul (1994) Gunyarat Ubolwun (1997) Wantanee Kumpeang (1997) Wassana Tuenwongse (1997) and Aegarat Cheuinta (1997) who found that income is related to quality of life of elderly people, that is elderly people with high incomes have higher quality of life than those with lower income, which also corresponds with the study of Suwimol Panawattanakul (1991) and Zhan (1992) who found that elderly people with high incomes often have better quality of life than those with lower incomes.

Assumption 1.6 Elderly people in extended families have better qualities of life than those in nuclear families.

Results that correspond with assumption 1.6 found that different family structures have different qualities of life in terms of cognitive, affective and social function at .05, where member with extended families have qualities of life in term of the cognitive, affective, and social function better than members with nuclear families. This may be due to members with extended families, which has many members who can help take care and meet the physical, affective, and social needs more than nuclear families (Tussanee Kreikultorn, 1993: 42) because family is the fundamental social institution that serves to meet our various needs, causing elderly people to feel that they are worthy, confident, and happy emotionally, creating a sense of good quality of life (Miller, et al., 986; 205). Along with the development theory of Erikson, who believed that admiration in the success of one's offspring build happiness and enjoyment to the lives of elderly people (Sompop Reungtrakul, 2005: 7). Additionally, the members of the sample group in extended families, which has many members itself, will have a lot of various problems, causing them to have to adapt to others in the family more than members who are in nuclear families resulting in thoughts, emotions and adaptability that are better. Therefore, sample group members in extended families have better qualities of life in terms of cognitive, affective, and social function than nuclear family members, corresponding with the study of Prapaporn Jinuntuya (1993) who found that elderly people who live with other members of their family have better qualities of life.

Results that did not correspond with assumption 1.6 found that sample group members with different family structures do not have significantly different qualities

of life at .05 in terms of physical, economic, or self-esteem, which shows that perceptions in these areas are not affected by family structure, because they are often dependent on personal factors, for example in terms of physical, it is dependent on how well the individual takes care of themselves from a younger age, and some health concerns are rooted in genetics such as diabetes, high blood pressure. In terms of economic, even in being part of family helps emotional and some finances, but does not address person expenses, causing some elderly people to feel their income is insufficient. Self-esteem is dependent on the original family and work. Family plays a minor role in terms of social acceptance and in urban societies even though members are in extended families, but members of their family have to go outside the home such as work, study, leaving the elderly person to take care of the house and children, resulting in health and economic problems (Wassana Tuenwongse, 1997: 144). Sample group members who are in nuclear families will not live in the same house as their children, but when there are problems they are supported by their children immediately, along with in the present the state tries to set welfare systems for the elderly such as health insurance where the elderly do not have to pay for medical treatment. Additionally, the sample group consists of elderly people who participate in the elderly group activities, allowing them to have daily exercise, as well as meet up with their peers, making them feel that they are worthy and their lives are more meaningful. Therefore, sample group members with nuclear families have qualities of life in terms of physical, economic and self-esteem that is not different from those in extended families.

Assumption 1.7 Elderly people who hold different rights to ownership of their present residence have different qualities of life.

Results that corresponds with assumption 1.7 found that ample group members who have the rights to ownership have significantly different qualities of life at .05 in terms of economic and self-esteem, when the differences are paired and the quality of life scores are tested using the Tukey HSD, it was found that those with the sole, shared, or relative-owned ownerships had better qualities of life with a statistical significance of .05 than those who do not own the rights to the place where they live. This may be due to the present where ownership of land is an asset for elderly people,

and in being the owner, or having some part of the ownership of the place of residence give them a sense of economic and financial stability in old age. As for elderly people who reside in shared ownership residences, they are no different from those living in the house of relatives because it was found that it was originally their house, but with old age they have conferred the rights of ownership to their children. However, those residing in homes they have no part in the ownership such as home for the elderly, will cause them to have economic and financial problems because part of their income is used to pay rent. Therefore, sample group members who have sole, shared, or relative-owned ownership of the current place of residence have better economic qualities of life than those who do not have any part in the ownership. This corresponds with the study of Sa-ing Chawarangkul (1995) who found that ownership of home property is related to material quality of life.

In terms of self-esteem quality of life, when testing difference in scores using the Tukey HSD it was found that those with sole and shared ownership of the place of residence have better qualities of life than those who do not play a part in ownership of the place of residence with a significance of .05. This may be due to in having ownership the elderly persons feel that they have some kind of asset insurance, causing them to see themselves positively and feel worthy, hence the feeling of self-esteem, along with the fact that in living in a place they own or partially own will make them more happy than living in places owned by other people. This can be seen in the study of Umpacha Panichchob (2003) who found that living in their own homes give elderly people a better quality of life. For these reasons, sample group members who own and those who share ownership have better self-esteem quality of life than those living in homes owned by others. This is different from the study of Prapaporn Jinuntuya (1993) who found that elderly people with their own homes have low qualities of life than those without homes. This may be due to difference in the characteristics of the sample group, because in that study, the sample group was limited to the Din Daeng elderly group, which is part of an urban society, which has high costs of living, therefore the results do not correspond with one another.

Results that do not correspond with assumption 1.7 found that sample group members with different ownerships to their current home of residence have no

significant differences at .05 in quality of life in terms of physical, cognitive, affective and social function. This shows that the perceptions of the elderly in terms of physical, cognitive, affective and social function does not change with rights of ownership. It can be explained that quality of life in these areas are rooted in personal factors that affects the elderly, not related to rights of ownership of present residence. Most of the sample group are generally in good health, and hence are able to participate in the activities of the elderly groups, therefore different ownerships of present residences do not affect quality of life in terms of cognitive, affective and social function.

Assumption 1.8 Elderly people without personal ailments have better qualities of life than those with personal ailments.

Results that correspond with assumption 1.8 found that differences in the sample group in terms of personal ailments have differences in quality of life at .05 in terms of physical, cognitive, affective, social function, economic, and self-esteem. Sample group members with no personal ailments, have better quality of life in terms of physical, cognitive, affective, social function, economic and self-esteem than those with personal ailments. This may be due personal ailments affecting health and the daily life of the elderly, such as sleeping and eating, as well as taking their interests away in various areas around themselves, due to anxiety concerning the illness they are suffering from, affecting the body, mind, emotions and society. Personal ailments take away from time and adds expenses in treating, affecting their economic and financial stability because income for elderly people often come from pensions or from their children. Additionally, in having a personal ailment, elderly people feel they have become a burden to their children or relatives who must take care of them, resulting in despair. For these reasons, sample group member with personal ailments have lower qualities of life in terms of physical, cognitive, affective, social function, economic, and self-esteem than those with no personal ailment. This corresponds with the study of Lauer (1982: 350) who stated that personal ailments lowers quality of life of elderly people, and the study of Prapaporn Jinuntuya (1993) and Umpacha Panichchob (2003) who found that elderly people with personal ailments have lower qualities of life than those without.

4. Selected Factors that are Able to Indicate Quality of Life of the Elderly

The discussion of the selected factors that are able to indicate quality of the according to assumption 2, are separated as follows

1. The selected factors, namely, age, sex, marital status, level of education, sufficiency of income, family type, the rights of ownership in the present residence and personal ailments is able to collectively determine the physical quality of life of elderly people.

Results of the study that correspond with the assumption found that personal ailments, sufficiency of income, sex, and marital status can collectively significantly determine the physical quality of life of elderly people. Personal ailments is the first factor that is chosen, showing that personal ailments is the most related to the physical quality of life of the elderly, because personal ailments directly affects to perceptions about body of the elderly, as well as affect their daily lives, which may change as a result. The second indicator is sufficiency of income, because elderly people with sufficient incomes are able to address their physical needs, therefore having an effect on their quality of life. The third indicator is sex, because sex affects daily lives, whereby females are confronted with more limitations causing them to depend on others (Hanlon and Pickett, 1984) affecting their physical quality of life. The fourth indicator is marital status because in having a spouse to help take care of their health and help stimulate one to care for each other, hence affecting the physical quality of life. When more indicators are added, it was found that the predictability coefficient had no statistical significance; a stepwise analysis was done to find the indicator of physical quality of life, which found five levels, which is combining all 8 factors and found that personal ailments, sufficiency of income, sex, and marital status are indicators of physical quality of life.

2. The selected factors, namely, age, sex, marital status, level of education, sufficiency of income, family type, the rights of ownership in the present residence and personal ailments is able to collectively determine the cognitive quality of life of elderly people.

Results of the study that correspond with the assumption found that personal ailments, sufficiency of income, sex and family type, are able to significantly

collectively indicate the cognitive quality of life of elderly people. Personal ailments is the first factor that is chosen, because personal ailments affects elderly people's perception of the cognitive, especially the feeling of not wanting to depend on others because sickness may limit elderly people from some activities, followed by negative thoughts and feelings, along with elderly people with ailments' anxiety about their condition, affecting their cognitive quality of life. The second indicator is sufficiency of income because those with sufficient incomes are confident in themselves, and are able to make decisions affecting their cognitive quality of life. The third indicator is sex, because the way females think are different from males, whereby females often ponder and consider things in detail, hence affecting the cognitive quality of life of elderly people. The fourth indicator is family type because the family offers care and meets the needs of elderly people, causing them to attain a kind of mental, emotional and contentment balance (Miller, et al., 1986: 205), affecting the cognitive quality of life of elderly people. Then when more indicators are added, it was found that there were no significant coefficient values. Stepwise analysis to find indicators of cognitive quality of life stops at 5 steps, that is when considering the 8 factors, it was found that personal ailments, sufficiency of income, sex and family type are the indicators of cognitive quality of life of elderly people.

3. The selected factors, namely, age, sex, marital status, level of education, sufficiency of income, family type, the rights of ownership in the present residence and personal ailments is able to collectively determine the emotional quality of life of elderly people.

Results that correspond with the assumption found that sufficiency of income, marital status, sex, family type, personal ailments, and age can collectively significantly indicate the affective quality of life of elderly people. Sufficiency of income is the first indicator chosen because it is the most significant indicator of the affective quality of life, due to elderly people with insufficient incomes often worry about their financial problems (Orem, 1991: 137). Sufficiency of income affects perception of the affective quality of life of elderly people. Marital status is the second indicator because in having a spouse to help take care of each other, elderly people feel warm and encouraged (Hubbard, et al., 1984: 266-9; Muhlenkamp and Sayles,

1986: 334-8) affecting the affective quality of life of elderly people. The third indicator is level of education, because it plays a role in organizing life experiences, enabling them to understand the world and life better, as well as its involvement in terms of values, ethics, and adaptability (Brady, 1983: 11-26; Prapaporn Jinuntuya, 1993: 21), which affects the affective quality of life of elderly people. The fourth indicator is sex because females are often more aware of emotions and feelings of others than males, therefore affecting the affective quality of life of elderly people. The fifth indicator is family type because it meets the emotional needs of elderly people, giving emotional balance and contentment in life (Miller, et al., 1986: 205), affecting the affective quality of life. The sixth indicator is personal ailments, because having a personal ailment gives rise to anxiety and negative emotions such as despair, hence affecting the affective quality of life of elderly people. The seventh indicator is age, because with increasing age, the body continues to deteriorate and prone to sickness, causing them to depend on others more (Hanlon and Pickett, 1984: 433-4) affecting the affective quality of life of elderly people. When more indicators are added it was found that there were no significant coefficient values. Stepwise analysis to find indicators of affective quality of life, stopped at 8, and when all 8 are considered it was found that sufficiency of income, marital status, level of education, family type, personal ailments and age are indicators of affective quality of life.

4. The selected factors, namely, age, sex, marital status, level of education, sufficiency of income, family type, the rights of ownership in the present residence and personal ailments is able to collectively determine the social function quality of life of elderly people.

Results that correspond with the assumption found that sufficiency of income, personal ailments and family type are able collectively significantly indicate the social function quality of life of elderly people. Sufficiency of income is the first indicator showing that is the most related to the social function quality of life, because it is an important factor in responding to the social needs of elderly people, hence elderly people who have sufficient incomes are happy and content with life (Hogstel, 1981: 466), hence affecting the social function quality of life of elderly people. The second indicator is personal ailments, because in having a personal ailment, elderly people are

not able to work or perform daily routines normally, as well as, interest in the world around them decreases, therefore personal ailments affects the social function quality of life of elderly people. The third indicator is family type, because family is a fundamental social institution that meets the social needs, enabling elderly people to feel confident and satisfied with life (Miller, et al., 1986: 205), hence affecting the social function quality of life of elderly people. When more indicators are added it was found that there were no significant coefficient values. Stepwise analysis to find indicators of social function quality of life stopped at 4, and when all 8 are considered it was found that sufficiency of income, personal ailments, and family type are indicators of social function quality of life.

5. The selected factors, namely, age, sex, marital status, level of education, sufficiency of income, family type, the rights of ownership in the present residence and personal ailments is able to collectively determine the economic quality of life of elderly people.

Results that correspond with the assumption found that sufficiency of income, the rights of ownership in the present residence, and level of education are able to collectively significantly indicate the economic quality of life of elderly people. Sufficiency of income is the first indicator, showing that it is the most related to the economic quality of life of elderly people, because it directly affects the economic perception of elderly people, along with elderly people having low or insufficient incomes are often plagued with anxiety about their financial situation (Orem, 1991: 137), therefore it affects the economic quality of life of elderly people. The second indicator is the rights of ownership in the present residence, because elderly people who are the owners or shared owners will have a sense of stability in terms of their economics and finances, thus affecting the economic quality of life of elderly people. The third indicator is the level of education because it is related to their personal profession and income (Brady, 1983: 11-26; Prapaporn Jinuntuya, 1993: 21) which affects the economic quality of life of elderly people. When more indicators are added no significant coefficient values were found. Stepwise analysis to find indicators stopped at 4 and when all 8 were considered it was found that sufficiency of income,

the rights of ownership in the present residence and level of education are indicators of the economic quality of life of elderly people.

6. The selected factors, namely, age, sex, marital status, level of education, sufficiency of income, family type, the rights of ownership in the present residence and personal ailments is able to collectively determine the self-esteem quality of life of elderly people.

Results that correspond with the assumption found that sufficiency of income, sex and personal ailments are able to collectively significantly indicate the self-esteem quality of life of elderly people. Sufficiency of income is the first indicator, showing that it is the most related to the self-esteem quality of life of elderly people, because having sufficient incomes enable elderly people to meet their needs, resulting in happiness, and contentment with life (Hogstel, 1981: 466), hence it is an indicator of self-esteem quality of life of elderly people. The second indicator is sex because females must depend on others because of their own limitations in performing daily routines (Hanlon and Pickett, 1984), making it an indicator of self-esteem quality of life of elderly people. The third indicator is personal ailments, because elderly people with personal ailments are often unable to perform daily tasks normally, requiring assistance to complete those tasks, resulting in the feeling that they have become a burden to others, resulting in a decreased sense of self-worth, affecting the self-esteem quality of life of elderly people. When more indicators were added, no significant coefficient values were found. Stepwise analysis to find indicators stopped at 4 levels, when all 8 factors were considered it was found that sufficiency of income, sex, and personal ailments were indicators of the self-esteem quality of life of elderly people.

Research Conclusions

This descriptive research aims to study quality of life of elderly people, differentiated by age, sex, marital status, level of education, sufficiency of income, family type, the rights of ownership in the present residence and personal ailments. The sample group in this study are elderly people over the age of 60 who participates in the activities of elderly groups under the care and supervision of the Bangkok Medical Service Department, totaling 9 groups namely, Bangkok Metropolitan Administration (BMA) Medical College and Vajira Hospital elderly group, Bangkok Metropolitan Administration (BMA) General Hospital elderly group, Taksin Hospital elderly group, Charoenkrung Pracharak Hospital elderly group, Laung Pho Thawisak Jutindharo Hospital elderly group, Nong Chok Hospital elderly group, Bangkok Metropolitan Administration (BMA) Lat Krabang Hospital elderly group, Ratchaphiphat Hospital elderly group, Sirindhorn hospital elderly group; totaling 388 persons. Data was collected using the demographic data questionnaire and the Pictorial Thai Quality of Life: PTQL, and analyzed using the t-test to find difference in mean quality of life scores and selected factors separated into 2 types namely, sex, sufficiency of income, family type, and personal ailments, and using One Way Analysis of Variance to find variance in the mean quality of life scores and selected factors separated into 3 or more types namely, age, marital status, level of education, and the rights of ownership in the present residence. Using stepwise analysis to find the multiple correlative coefficient between the indicators that is the selected factors, namely age, sex, marital status, level of education, sufficiency of income, family type, the rights of ownership in the present residence and personal ailments and the criteria, namely quality of life, as separated as follows.

1. The Selected Factors of the Sample Group

The sample group consists of 388 elderly persons, most between the ages of 60-69 (48.97%), with an average age of 69.69 years. Most are female (78.35%), are married and have an elementary education (46.65% and 35.82% respectively). Most have incomes lower than 5,000 Baht (37.63%) with an average income of 11,260.84, most feeling that their income is sufficient (77.06%) most with nuclear families (60.82%). Most have the sole right to ownership of their current residence (42.01%)

and have personal ailments (70.88%), most with a single ailments (52.73%), most common ailments is high blood pressure (49.82%) followed by high cholesterol (30.18%).

2. Information about Quality of Life of the sample group

The sample group has high quality of life in terms of social function and self-esteem (Mean = 9.98, S.D. = 2.42; Mean = 10.55, S.D. = 3.67 respectively). The quality of life in terms of physical, cognitive, affective, and economic were mid-range (Mean = 9.60, S.D. = 3.45; Mean = 5.95, S.D. = 2.28; Mean = 10.40, S.D. = 3.93; Mean = 4.29, S.D. = 1.96, respectively).

3. Selected Factors Pertaining to Quality of Life of the Elderly

Age is not related to the quality of life in terms of physical, cognitive, affective, social function, economic, and self-esteem of elderly people.

Sex is related to the quality of life in terms of physical, cognitive, affective, and self-esteem, but not related to quality of life in terms of social function and economic.

Marital status is related to the quality of life in terms of physical, affective, social function, economic, and self-esteem, but not related to cognitive quality of life.

Level of education is related to the quality of life in terms of affective, but not related in terms of physical, cognitive, social function, economic, and self-esteem.

Sufficiency of income is related to the quality of life in terms of physical, cognitive, affective, social function, economic, and self-esteem.

Family type is related to the quality of life in terms of cognitive, affective, and social function, but not related to physical, economic, and self-esteem.

The right of ownership in the present residence is related to the quality of life in terms of economic and self-esteem, but not related in terms of physical, cognitive, affective and social function.

Personal ailments is related to the quality of life in terms of physical, cognitive, affective, social function, economic and self-esteem.

4. Selected Factors that are Able to Indicate Quality of Life of the Elderly

Personal ailments, sufficiency of income, sex, and marital status are able to explain the variance in the physical quality of life of elderly people at 28.6% with a statistical significance of .001.

Personal ailments, sufficiency of income, sex, and family type are able to explain the variance in the cognitive quality of life of elderly people at 13.5% with a statistical significance of .001.

Sufficiency of income, marital status, level of education, sex, family type personal ailments and age can explain the variance in the affective quality of life of elderly people at 20.0% with a statistical significance of .001.

Sufficiency of income, personal ailments and family type can explain variance in the social function quality of life at 5.9% with a statistical significance of .001.

Sufficiency of income, the right of ownership in the present residence and level of education can explain variance in the economic quality of life at 45.3% with a statistical significance of .001.

Sufficiency of income, sex and personal ailments can explain variance in the self-esteem quality of life at 6.8% with a statistical significance of .001.

Suggestions from the Research Results

1. The elderly people in the study averaged 69.69 years and most have a personal ailments, and along with the research result of the selected factors that are able to indicate quality of life of elderly people found that personal ailments is a factor that can explain variance in quality of life of elderly people in almost all facets, therefore there should be promotions of health for the elderly and those close to them, as well as state and private agencies should help to draft policies to take care of the elderly, by organizing health awareness events and medical checkups annually, to

prevent onset of illness for the elderly, which will help save money to treat elderly patients, and promote quality of life of elderly people.

2. Even though the elderly people in the study are older than 60, and most have personal ailments, but the research results found that the sample group have high qualities of life in terms of social function and self-esteem. As for the quality of life in terms of physical, cognitive, affective, and economic, it was found that it was at mid-range, this is probably due in part to their participation in the activities of elderly groups which help to promote mental and physical well-being for the elderly, therefore these activities should be promoted and advertised to nearby elderly people of the benefits of these activities, to improve their quality of life.

3. Elderly people who are widowed, divorced or separated have qualities of life in terms of physical, affective, economic, and self-esteem that is lower than their married counterparts, therefore this group of elderly people should be encouraged to join activities that will improve their quality of life in terms of physical, affective, economic and self-esteem.

4. Elderly people with sufficient incomes have better qualities of life than those with insufficient income to their expenses, and from the research results of the selective factors that are able to indicate quality of life of elderly people, it was found that the sufficiency of income is a factor that can explain variance of quality of life of elderly people in all facets, therefore elderly people who are still able bodied should be encouraged to take jobs according to their abilities, to build income, resulting self-esteem and a better quality of life.

5. Elderly people in extended families have better qualities of life in terms of cognitive, affective, and social function than those in nuclear families, but families in urban area are most often nuclear families, therefore there should be campaigns to promote children and grandchildren to visit elderly relatives, and promote good relationships within the family, instilling values of loyalty to members of the family, as well as take care and meet the needs of the mind, body and society of elderly people. Additionally, there should be counseling units for the elderly, especially, those in nuclear families, to make them feel worthy, resulting in contentment in life and a better quality of life.

Suggestions for Future Research

1. There should be a comprehensive study of quality of life of elderly people, because this study is a study specifically of elderly people living in Bangkok, in order to create a study that is more representative of the general population that can serve as an approach in developing national policies concerning the elderly.

2. Because this study is a study on elderly people who participate in the group activities for the elderly, under the care and supervision of the Bangkok Medical Service Department, in order to make the study more comprehensive, there should be studies on elderly populations that do not participate in these activities and a comparison study to bring the results to develop approaches that are appropriate for each group.

3. There should be a qualitative study about quality of life of elderly people in order to acquire detailed information that can serve as a database in promoting higher qualities of life for the elderly.

4. There should be studies of other factors that are related to quality of life of elderly people, namely, familial relationships, attitudes of family members towards the elderly person, level of education of children and caretakers, participation in religious ceremonies, present living conditions, the stability of current residence, time of illness, behavioral patterns pertaining to health such as eating habits, alcohol consumption or stimulants, smoking, rest, waste excretion etc.

5. There should be further studies on male elderly because most of the sample group in this study were female, causing the result of the study to be unable to explain quality of life of male participants, therefore, a study of male groups will help to build up a database that will help to promote a better quality of life for the elderly.

Research Limitations

1. This is a cross-sectional descriptive research, whereby information pertaining to quality of life of elderly people are from their own perceptions in the present (December 4, 2007 to February 28, 2008), thus not representative of elderly population of Bangkok.

2. The Pictorial Thai Quality of Life: PTQL is a tool recently developed, and this is the first study to use it, resulting in some pictures that may cause some misunderstandings in terms of question, therefore, the results might not be accurate such as questions 6, 8, and 9.

3. Due to limitation in managing group activity attendance, most of sample group was chosen by the staff, resulting in the good health and voluntary of the subjects, due to selection bias.

4. Most of the sample group was female, because most of the members of the elderly groups under the care and supervision of the Bangkok Medical Service Department are mostly women (78.37%) (as seen in Table 20), resulting in limited numbers of male subjects.

Table 20 Male and female members of elderly groups under the care and supervision of the Bangkok Medical Service Department.

Elderly Groups	Male Members (persons)	Female Members (persons)
BMA Medical College and Vajira Hospital elderly group	674	1,812
BMA General Hospital elderly group	268	727
Taksin Hospital elderly group	46	794
Charoenkrung Pracharak Hospital elderly group	163	846
Laung Pho Thawisak Jutindharo Hospital elderly group	48	104
Nong Chok Hospital elderly group	117	233
BMA Lat Krabang Hospital elderly group	128	420
Ratchaphiphat Hospital elderly group	138	314
Sirindhorn hospital elderly group	35	608
Total	1,617	5,858

BIBLIOGRAPHY

ENGLISH

- Andrews, H.A. and Roy, S.C.. (1991). *The Roy Adaptation Model*. California: Appleton & Lange.
- Barrow, G.M. and Smith, P.A.. (1979). *Aging, Ageism and Society*. St. Paul Minn: West Publishing Company.
- Brady, E.M.. (1983). "Personal Growth and the Elderhostel Experience." *Lifelong Learning*. Vol.7 No.3 (November 1983): 11-26.
- Burckhardt, C.S.. (1985). "The Impact of Arthritis on Quality of Life." *Nursing Research*. 34(1985): 11-16.
- Cockerham, W.C.. (1982). *Medical Sociology*. New Jersey: Prentice Hall.
- Cohen, S. and Wills, T.M.. (1985). "Stress, Social Support, and the Buffering Hypothesis." *Psychological Bulletin*. 98(1985): 310-357.
- Cowgill, D.O.. (1972). *Aging and Modernization : A Theory of Aging in Cross-Culture Perspective*. New York: Meredith Corporation.
- Denham, M.J.. (1991). *Care of the Long-Stay Elderly Patient*. 2nd ed. London: Chapman and Hill.
- Edward, J.N. Klem, M. and David, L.. (1973). "Correlated of Life Satisfaction: A Re-Examination." *Journal of Gerontology*. 28(1973): 497-502.
- Flanagan, J.C.. (1978). "A Research Approach to Improving Our Quality of Life." *American Psychologist*. 22(February 1978): 138-147.

- Hanlon, J.J. and Pickett, G.E.. (1984). *Public Health: Administration and Practice*. 8th ed. St. Louis: Time Mirror/Mosby College Publishing.
- Haug, M. and Folmar, S.. (1986). "Longevity, Gender, and Life Quality." *Journal of Health and Social Behavior*. 27(December 1986): 332-345.
- Hogstel, M.O.. (1981). *Nursing Care of The Older Adult*. Texas: Delmar Publishers Inc.
- Hubbard, P. Muhlenkamp, A.F. and Brown, N.. (1984). "The Relationship, Social Support, and Between Social Support and Self-Care Practice." *Nursing Research*. 33(1984): 266-269.
- Larson, R.. (1978). "Thirty Years of Research on the Subjective Well-Being of Older Americans." *Journal of Gerontology*. 33(September 1978):109-125.
- Lauer, R.H.. (1982). *Social Problems and the Quality of Life*. 2nd ed. Iowa: Wm.C.Brown Company Publishes.
- Markides, K.S. and Martin, H.W.. (1979). "A Causal Model of Life Satisfaction among the Elderly." *Journal of Gerontology*. 34(January 1979): 86-93.
- Matsubayashi, K. Okumiya, K. Osaki, Y. Fulisawa, M. and Doi, Y.. (1997). "Quality of Life of Old People Living in the Community." *Lancet*. 350(November 1997): 1521-1522.
- Miller, S.S. Miller, J.A. and Miller, D.E.. (1986). *Lifespan Plus: The Definitive Guide to Health and Well-Being for the Rest of Your Life*. New York: Macmillan Publishing Company.
- Muhlenkamp, A.F. and Sayles, J.A.. (1986). "Self-Esteem, Social Support, and Positive Health Practices." *Nursing Research*. 35(1986):334-338.
- Orem, D.E.. (1980). *Nursing: Concepts of Practice*. New York: Mc. Graw-Hill Book Company.
- Orem, D.E.. (1991). *Nursing: Concepts of Practice*. St. Louise: Mosby-Year Book.

- Pherson, Mc. and Barry, D.. (1983). *Aging as A Social Process*. Toronto: Butterworth.
- Pickett, G. and Hanlon, J.J.. (1990). *Public Health: Administration and Practice*.
St. Louis: Times Mieceor.
- Robert, S.J.. (1988). "Social Support and Help Seeking: Review of The Literature."
Advances in Nursing Sciences. 10(1988): 10-11.
- Spietzter, E. and Synder, E.E.. (1974). "Correlated of Life Satisfaction Among the
Aged." *Journal of Gerontology*. 29(July 1974): 454-458.
- Spitzer, W.O., et al.. (1987). "State of Science 1986: Quality of Life and Function
Status as Target Variables for Research." *Journal of Chronic Disease*.
40(1987):465-471.
- Stromberg, M.F.. (1984). "Selecting and Instrument to Measure Quality of Life."
Oncology Nursing Forum. 11(September-October 1984): 88-91.
- Sucheera Phattharayuttawat, Thienchai Ngamthipwatthana, and Buncha
Pitiyawanun. (2006). "The Development of the Pictorial Thai Quality of
Life." [Online]. Retrieved : September 13. From
http://www.medassocthai.org/journal/files/Vol88_No11_1605.pdf.
- Takahashi, Y.. (1979). *Quality of Life in Thailand: A Socio-Economic Analysis*.
A Thesis for the Degree of Master of Engineering. Asian Institute of
Technology.
- Tidemark, J. Zethraeus, N. Svensson, O. Tornkvist, H. and Ponzer, S.. (2002).
"Femoral Neck Fractures in the Elderly: Functional Outcome and Quality of
Life According to EuroQol." *Quality of Life Research*. 11(2002): 473-481.
- Tran, T.V. Chatter, L. and Wright, R.. (1991). "Health, Stress, Psychological
Resources, and Subjective Well-Being Among Older Blacks." *Psychology and
Aging*. 6(1991): 100-108.

Uenishi, Y. Tsumura, H. Miki, T. and Shiraki, K.. (2003). "Quality of Life of Elderly Japanese Patients with Glaucoma." *International of Journal Nursing Practice*. 9(2003): 18-25.

UNESCO. (1980). "Evaluating the Quality of Life in Belgium." *Social Indicators Research*. 8(September 1980): 312.

Ward, R.A., et al.. (1984). "Subjective Network Assessment and Subject Well-being." *Journal of Gerontology*. 39(1984): 93-101.

Yurick, A.G., et al.. (1984). *The Aged Person and the Nursing Process*. Norwalk: Appleton Century-Crofts.

Zhan, L.. (1992). "Quality of Life: Concept and Measurement Issues." *Journal of Advanced Nursing*. 17(1992): 795-800.

THAI

กชกร สังขชาติ. (2536). (Kochakorn Sanghchart, 1993). ความรู้เบื้องต้นเกี่ยวกับผู้สูงอายุ.
ชลบุรี : มหาวิทยาลัยบูรพา.

กันยารัตน์ อุบลวรรณ. (2540). (Gunyarat Ubolwun, 1997). พฤติกรรมการดูแลตนเองและ
คุณภาพชีวิตของผู้สูงอายุในภาคกลางของประเทศไทย. วิทยานิพนธ์วิทยาศาสตร์
มหาบัณฑิต, สาขาวิชาการพยาบาลผู้ใหญ่ คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล.

กระทรวงการพัฒนาสังคมและความมั่นคงของมนุษย์ สำนักงานส่งเสริมสวัสดิภาพและพิทักษ์เด็ก
เยาวชน ผู้ด้อยโอกาส คนพิการ และผู้สูงอายุ. (2549). (The Ministry of Social

Development and Human Security, 2006). “สถานการณ์ผู้สูงอายุไทย พ.ศ. 2547.”

[ออนไลน์]. เข้าถึงเมื่อ : 4 ตุลาคม 2549 . จาก <http://oppo.opp.go.th/info/Binder1.pdf>.

กระทรวงเทคโนโลยีสารสนเทศและการสื่อสาร สำนักงานสถิติแห่งชาติ. (2549). (The Ministry of Information and Communication Technology, 2006). “ประชากรโลก : ประชากรไทย 2547.” [ออนไลน์]. เข้าถึงเมื่อ : 31 สิงหาคม 2549. จาก service.nso.go.th/nso/r.jsp?f=file_upload/87.pdf.

กระทรวงมหาดไทย กรมการปกครอง. (2549). (The Ministry of Interior, 2006). “ข้อมูลสถิติเกี่ยวกับจำนวนประชากร.” [ออนไลน์]. เข้าถึงเมื่อ : 4 ตุลาคม 2549. จาก [http://www.dopa.go.th/cgi-bin/people2_stat.exe?YEAR=48&LEVEL=1&PROVINCE=10%23%A1%C3%D8%A7%E0%B7%BE%C1%CB%D2%B9%A4%C3&DISTRICT=&TAMBON=.](http://www.dopa.go.th/cgi-bin/people2_stat.exe?YEAR=48&LEVEL=1&PROVINCE=10%23%A1%C3%D8%A7%E0%B7%BE%C1%CB%D2%B9%A4%C3&DISTRICT=&TAMBON=)

กระทรวงสาธารณสุข กรมการแพทย์ สถาบันเวชศาสตร์ผู้สูงอายุ. (2549). (The Ministry of Public Health, 2006). “สุขภาพผู้สูงอายุไทย.” [ออนไลน์]. เข้าถึงเมื่อ : 30 สิงหาคม 2549. จาก <http://www.agingthai.org/file/content/1111.pdf>.

จิราพร เกศพิชญวัฒนา และสุวิณี วิวัฒน์วานิช. (2547). (Jiraporn Katepitchwattana and Suvinee Vivatvanich, 2004). การศึกษานโยบายและการดำเนินการด้านผู้สูงอายุและกลุ่มโรคไม่ติดต่อของกรุงเทพมหานคร. กรุงเทพมหานคร : โรงพิมพ์แห่งจุฬาลงกรณ์มหาวิทยาลัย.

จำเรียง กุรมะสุวรรณ, นิตยา ภาสุนันท์และวินัส ตันติบูล. (2532). (Jumreang Kurmasuwan, Nittaya Pasunun and Venus Tuntibul, 1989). รายงานการวิจัยการศึกษาความสัมพันธ์ระหว่างปัจจัยด้านสถานภาพส่วนบุคคลความสามารถในการดูแลตนเองและคุณภาพชีวิตของผู้สูงอายุ. กรุงเทพมหานคร : คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล.

ทัศนีย์ เกริกกุลธร. (2536). (Tussanee Kreikultorn, 1993). การศึกษาการสนับสนุนทางสังคมและการปรับตัวของผู้สูงอายุในเขตเทศบาลเมืองสระบุรี. วิทยานิพนธ์วิทยาศาสตร์ มหาวิทยาลัยมหิดล, สาขาวิชาพยาบาลศาสตร์ คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล.

นภาพร ชโยวรรณ. (2542). (Napaporn Chayowan, 1999). “สถานการณ์ผู้สูงอายุไทยในปัจจุบัน.” ใน : คณะกรรมการดำเนินการจัดกิจกรรมปีสากลว่าด้วยผู้สูงอายุด้านวิชาการ. การประชุมวิชาการแห่งชาติว่าด้วยผู้สูงอายุ “ผู้วัยสูงอายุด้วยคุณภาพ” (หน้า 54-92). กรุงเทพมหานคร : โรงพิมพ์แห่งจุฬาลงกรณ์มหาวิทยาลัย.

นิพนธ์ คันธเสวี. (2526). (Nipon Kuntsawee, 1983). การศึกษาและวัฒนธรรม. กรุงเทพมหานคร : บริษัท ประชาชน จำกัด.

นिसารัตน์ ศิลปเดช. (2539). (Nisarath Silapadet, 1996). ประชากรกับการพัฒนาคุณภาพชีวิต. กรุงเทพมหานคร : พิษณุการพิมพ์.

บรรลุ ศิริพานิช. (2535). (Bunlu Siripanich, 1992). คู่มือเตรียมตัวก่อนเกษียณอายุการงาน. พิมพ์ครั้งที่ 2. กรุงเทพมหานคร : บริษัท พี. ที. เอ. เบสท์ ซัพพลาย จำกัด.

บุญธรรม กิจปรีดาบริสุทธิ์ และสมคิด อิศระวัฒน์. (2526). (Buntom Kijpreedaborisud and Somkid Issarawat, 1983). ประชากรศึกษา : ประชากรศึกษากับการปรับปรุงคุณภาพชีวิต. พิมพ์ครั้งที่ 2. กรุงเทพมหานคร : อักษรบัณฑิต.

ประภาพร จินันทุยา. (2536). (Prapaporn Jinuntuya, 1993). คุณภาพชีวิตของผู้สูงอายุในชมรมทางสังคมผู้สูงอายุคนแดง. วิทยานิพนธ์วิทยาศาสตรมหาบัณฑิต, สาขาวิชาพยาบาลศาสตร์ คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล.

ประเวศ วะสี. (2543). (Pravet Vasee, 2000). “คุณภาพผู้สูงอายุที่พึงปรารถนา.” ใน : สุทธิชัย จิตะพันธ์กุล, บรรณาธิการ. การประมวณ วิเคราะห์ สังเคราะห์ การประชุมวิชาการแห่งชาติว่าด้วยผู้สูงอายุ “ผู้วัยสูงอายุด้วยคุณภาพ” (หน้า 9-14). กรุงเทพมหานคร : โรงพิมพ์แห่งจุฬาลงกรณ์มหาวิทยาลัย.

พนิชฐา พานิชชีวะกุล. (2537). (Panistha Panichacheevakul, 1994). การพัฒนาเครื่องมือวัดคุณภาพชีวิตที่เป็นสหมิตสำหรับผู้สูงอายุในชนบท. วิทยานิพนธ์สาธาณสุขศาสตรดุษฎีบัณฑิต, คณะสาธาณสุขศาสตร มหาวิทาลัยมหิดล.

มารศรี นุชแสงพลี. (2532). (Marasri Nuchseangplee, 1989). ปัจจัยที่มีอิทธิพลต่อความพึงพอใจในชีวิตของผู้สูงอายุ ศึกษาเฉพาะกรณีผู้สูงอายุในชุมชนบ่อนไก่ กรุงเทพมหานคร. วิทยานิพนธ์สังคมวิทยาและมานุษยวิทยา มหาบัณฑิต, คณะสังคมวิทยาและมานุษยวิทยา มหาวิทยาลัยธรรมศาสตร์.

มูลนิธิสถาบันวิจัยและพัฒนาผู้สูงอายุไทย. (2550). (Foundation of Thai Gerontology

Research and Development, 2007). สถานการณ์ผู้สูงอายุไทย พ.ศ. 2549.

กรุงเทพมหานคร : โรงพิมพ์เดือนตุลา.

ราชบัณฑิตยสถาน. (2525). (The Royal Institute, 1982). พจนานุกรมฉบับราชบัณฑิตยสถาน.

กรุงเทพมหานคร : อักษรเจริญทัศน์.

รัตนา เพ็ชรอุไร และอดุลย์ วิริยเวชกุล. (2538). (Rattana Peathurai and Adul Viriyavetkul,

1995). “ผู้สูงอายุในประเทศไทย : ประเด็นที่ควรศึกษาวิจัย.” ใน : รัตนา เพ็ชรอุไร และ

อดุลย์ วิริยเวชกุล, บรรณาธิการ. ประมวลประเด็นการวิจัยและบรรณานุกรมเอกสารการวิจัย

เรื่องผู้สูงอายุในประเทศไทย (หน้า 1-9). กรุงเทพมหานคร : โรงพิมพ์สุภาวณิชการพิมพ์.

รุ่งโรจน์ พุ่มริ้ว. (2545). (Rungroj Poomriew, 2002). สวัสดิการสำหรับผู้สูงอายุและบทบาท

ของสุขศึกษาในการส่งเสริมสุขภาพผู้สูงอายุ. กรุงเทพมหานคร : โรงพิมพ์เจริญดีการพิมพ์.

วันที ขำเพ็ง. (2540). (Wantanee Kumpeang, 1997). ปัจจัยที่มีความสัมพันธ์กับคุณภาพชีวิต

ผู้สูงอายุชนบทจังหวัดนครราชสีมา. วิทยานิพนธ์วิทยาศาสตร์มหาบัณฑิต, สาขาวิชา

พยาบาลสาธารณสุข คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหิดล.

วาสนา ถิ่นวงษ์. (2540). (Wassana Tuenwongse, 1997). พฤติกรรมการดูแลตนเองและ

คุณภาพชีวิตของผู้สูงอายุในกรุงเทพมหานคร. วิทยานิพนธ์พยาบาลศาสตรมหาบัณฑิต,

สาขาวิชาการพยาบาลผู้ใหญ่ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

วรรณภา กุมารจันทร์. (2543). (Wunna Gumajandra, 2000). คุณภาพชีวิตของผู้สูงอายุในเขตภาคใต้ตอนบน. วิทยานิพนธ์พยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลผู้สูงอายุ บัณฑิตวิทยาลัย มหาวิทยาลัยเชียงใหม่.

วรรณธิดา อิมสุตใจ. (2540). (Wunthida Imsutjai, 1997). คุณภาพชีวิตของสตรีวัยหมดประจำเดือนในภาคตะวันออกเฉียงเหนือ. วิทยานิพนธ์พยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลแม่และเด็ก บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

ศรีธรรม ธนะภูมิ. (2535). (Srithum Thanapoom, 1992). พัฒนาการทางอารมณ์และบุคลิกภาพ. กรุงเทพมหานคร : ภาควิชาจิตเวชศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล.

ศรีเรือน แก้วกังวาล. (2545). (Sriruen Kaewkungwal, 2002). จิตวิทยาพัฒนาการชีวิตทุกช่วงวัย. พิมพ์ครั้งที่ 8 แก้ไขเพิ่มเติม. กรุงเทพมหานคร : โรงพิมพ์มหาวิทยาลัยธรรมศาสตร์.

ศศิพัฒน์ ยอดเพชร. (2542). (Sasipat Yodpetch, 1999). “แนวคิดด้านสวัสดิการสังคมผู้สูงอายุที่มีคุณภาพ.” ใน : คณะกรรมการดำเนินการจัดกิจกรรมปีสากลว่าด้วยผู้สูงอายุ ด้านวิชาการ. การประชุมวิชาการแห่งชาติว่าด้วยผู้สูงอายุ “ผู้สูงอายุด้วยคุณภาพ” (หน้า 54-92). กรุงเทพมหานคร : โรงพิมพ์แห่งจุฬาลงกรณ์มหาวิทยาลัย.

สุกโชก สิงห์กันต์. (2550). (Sukchoke Singhagunt, 2007). “หายเหงาถ้าเข้าใจ”. ใน วิทยาธิฐานันท์, บรรณาธิการ. สาระสุขภาพผู้สูงอายุ (หน้า 107-110). กรุงเทพมหานคร : บริษัท ยูเนี่ยน ครีเอชั่น จำกัด.

ศิริไชย หงส์สงวนศรี. (2548). (Sirichai Hongnguan Sri, 2005). “พัฒนาการทางจิตใจ.”

ใน : มาโนช หล่อตระกูล และปราโมทย์ สุคนิษฐ์, บรรณาธิการ. จิตเวชศาสตร์ รามาธิบดี
(หน้า 1-19). กรุงเทพมหานคร : บริษัท บียอนด์ เอ็นเทอร์ไพรซ์ จำกัด.

สมจิตต์ สุพรรณทัศน์และนิภา มนุษย์ปิจุ. (2525). (Somchit Supharntut and Nipha

Manuyapiju, 1982). ประชากรกับคุณภาพชีวิต. กรุงเทพมหานคร : โรงพิมพ์ศรีอนันต์.

สมภพ เรื่องตระกูล. (2548). (Sompop Reungtrakul, S., 2005). ตำราจิตเวชศาสตร์.

พิมพ์ครั้งที่ 9. กรุงเทพมหานคร : โรงพิมพ์เรือนแก้วการพิมพ์.

สอิ่ง ชวารังกูร. (2538). (Sa-ing Chawarangkul, 1995). ความสัมพันธ์ระหว่างปัจจัยคัดสรรกับ

คุณภาพชีวิตของผู้สูงอายุในจังหวัดสุราษฎร์ธานี. วิทยานิพนธ์วิทยาศาสตรมหาบัณฑิต,
สาขาวิชาพยาบาลสาธารณสุข คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหิดล.

สาวิตรี ลิ้มชัยอรุณเรือง. (2536). (Savitree Limchairunrung, 1993). ปัจจัยที่มีผลต่อการรับรู้

กระบวนการสูงอายุและคุณภาพชีวิต. วิทยานิพนธ์การศึกษาศาสตรดุษฎีบัณฑิต,
สาขาพัฒนศึกษาศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยศรีนครินทรวิโรฒ ประสานมิตร.

สุรกุล เจนอบรม. (2534). (Surakul Jenobrom, 1991). วิทยาการผู้สูงอายุ (Gerontology).

กรุงเทพมหานคร : ภาควิชาการศึกษาออกโรงเรียน คณะครุศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย.

สุจิตรา นิลเลิศ. (2539). (Sujittra Nilleard, 1996). ความสัมพันธ์ระหว่างการได้รับการอุปถัมภ์

จากบุตรกับคุณภาพชีวิตผู้สูงอายุไทยในชนบท จังหวัดสุพรรณบุรี. วิทยานิพนธ์ประชากร
ศาสตรดุษฎีบัณฑิต, สถาบันวิจัยประชากรและสังคม มหาวิทยาลัยมหิดล.

สุชีรา ภัทรายุทธวรรณ. (2546). (Sucheera Phattharayuttawat, 2003). ทฤษฎีการวิจัยและการใช้สถิติในการวิจัยเชิงจิตวิทยา (Research Theory and Statistical Applied in Psychology). กรุงเทพมหานคร : ภาควิชาจิตเวชศาสตร์ คณะแพทยศาสตร์ศิริราชพยาบาล มหาวิทยาลัยมหิดล.

_____. (2548). (Sucheera Phattharayuttawat, 2005). คู่มือการวัดทางจิตวิทยา (Manual of Psychological Testing). พิมพ์ครั้งที่ 3. กรุงเทพมหานคร : สำนักพิมพ์ เมดิคัล มีเดีย.

สุพัฒน์ ชีรเวชเจริญชัย. (2546). (Supat Teeravechcharoenchai, 2003). สุขภาพเพื่อชีวิต. กรุงเทพมหานคร : สำนักพิมพ์มหาวิทยาลัยเกษตรศาสตร์.

สุวิมล พนาวัฒน์กุล. (2534). (Suwimol Panawattanakul, 1991). อ้อม โนทัศน์ ความสามารถในการดูแลตนเอง และคุณภาพชีวิตของผู้สูงอายุ. วิทยานิพนธ์วิทยาศาสตร์มหาบัณฑิต, สาขาวิชาพยาบาลศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

เส้นทางสุขภาพ.(2551). (Yourhealthyguide, 2008). “การป้องกันและควบคุมโรคความดันโลหิตสูง.” [ออนไลน์]. เข้าถึงเมื่อ : 2 มิถุนายน 2551. จาก

<http://www.yourhealthyguide.com/article/ah-hypertension-prevent.html>.

สำนักงานคณะกรรมการสาธารณสุขมูลฐาน. (2531). (Office of the Public Health Commission, 1988). คู่มือการส่งเสริมสุขภาพผู้สูงอายุ. พิมพ์ครั้งที่ 2. กรุงเทพมหานคร : สำนักงานปลัดกระทรวง กระทรวงสาธารณสุข.

สำนักมาตรฐานการพัฒนาสังคมและความมั่นคงของมนุษย์. (2548). (The Social Development Standard and Humanity Security Office, 2005). รายงานผลการศึกษาโครงการ กำหนดดัชนีคุณภาพชีวิต. กรุงเทพมหานคร : สำนักมาตรฐานการพัฒนาสังคมและความมั่นคงของมนุษย์, สำนักงานปลัดกระทรวง กระทรวงการพัฒนาสังคมและความมั่นคงของมนุษย์.

อนุชาติ พวงสำลีและอรทัย อัจฉริย์. (2541). (Anuchad Puangsumlee and Oratai Arjum, 1998). การพัฒนาเครื่องชี้วัดคุณภาพชีวิตและสังคมไทย. พิมพ์ครั้งที่ 2. กรุงเทพมหานคร : สำนักงานกองทุนสนับสนุนการวิจัย.

อัจฉรา นวจินดาและขจีจรัส ภิรมย์ธรรมศิริ. (2534). (Achara Navachinda and Kajeejaras Piromtumsiri, 1991). รายงานการวิจัยเรื่องความพึงพอใจ : ตัวแปรกลางการพัฒนาคุณภาพชีวิตผู้สูงอายุ. กรุงเทพมหานคร : ภาควิชาคหกรรมศาสตร์ คณะเกษตร มหาวิทยาลัยเกษตรศาสตร์.

อัมภัสชา พานิชชอบ. (2546). (Umpacha Panichchob, 2003). การศึกษาคุณภาพชีวิตของผู้สูงอายุในสถานสงเคราะห์คนชราบ้านบางแค และสถานที่พักผู้สูงอายุเอกชนใน กรุงเทพมหานครและปริมณฑล. วิทยานิพนธ์วิทยาศาสตรมหาบัณฑิต, สาขาวิชาสุขภาพจิต คณะแพทยศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย.

อุมาพร อุดมทรัพย์กุล. (2536). (Umaporn Udomsupayakul, 1993). ปัจจัยที่มีอิทธิพลต่อความพึงพอใจในชีวิตของผู้สูงอายุในชุมชนย่อยเขตเทศบาลเมืองสุพรรณบุรี. วิทยานิพนธ์วิทยาศาสตรมหาบัณฑิต, สาขาวิชาสถิติ คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหิดล.

เอกรัตน์ เชื้ออินตา. (2540). (Aegarar Cheuinta, 1997). พฤติกรรมการดูแลตนเองและคุณภาพชีวิตของผู้สูงอายุในภาคเหนือตอนบนของประเทศไทย. วิทยานิพนธ์พยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลผู้ใหญ่ คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล.

อำนาจ วังจิ้นและพิมพ์พร ฟองหล้า. (2546). (Umnat Wangjin and Pimporn Fonglum, 2003). ดัชนีคุณภาพชีวิตผู้สูงอายุในเขตกรุงเทพมหานคร. กรุงเทพมหานคร : มหาวิทยาลัยศรีปทุม.





APPENDIX A

RESEARCH TOOLS

เลขที่.....

แบบสอบถามผู้สูงอายุ

แบบสอบถามฉบับนี้แบ่งออกเป็น 2 ส่วน ดังต่อไปนี้

ส่วนที่ 1 แบบสอบถามข้อมูลส่วนบุคคลของผู้สูงอายุ

ส่วนที่ 2 แบบประเมินคุณภาพชีวิตไทยแบบรูปภาพ (Pictorial Thai Quality of Life : PTQL)

ส่วนที่ 1 แบบสอบถามข้อมูลส่วนบุคคลของผู้สูงอายุ

คำแนะนำ : ขอให้ท่านเติมข้อความลงในช่องว่างหรือทำเครื่องหมาย ✓ ลงในช่องที่เห็นว่าตรงกับความเป็นจริงของท่านมากที่สุด

1. ปัจจุบันท่านอายุ.....ปี (.....)

2. เพศ (.....)

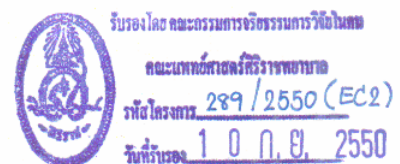
ชาย หญิง

3. สถานภาพสมรส (.....)

สถานภาพสมรสโสด

สถานภาพสมรสหม้าย หย่า และแยกกันอยู่

สถานภาพสมรสคู่



4. ระดับการศึกษา (.....)

- ไม่ได้รับการศึกษา ระดับประถมศึกษา
- ระดับมัธยมศึกษา ระดับอุดมศึกษาขึ้นไป

5. รายได้

5.1 ปัจจุบันท่านมีรายได้เฉลี่ยต่อเดือน.....บาท (.....)

5.2 ความเพียงพอของรายได้ (.....)

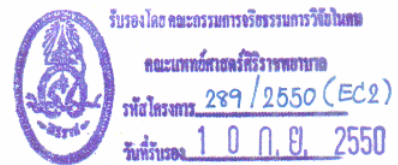
- รายได้เพียงพอกับค่าใช้จ่ายตามความรู้สึกของผู้สูงอายุ
- รายได้ไม่เพียงพอกับค่าใช้จ่ายตามความรู้สึกของผู้สูงอายุ

6. ลักษณะครอบครัว (.....)

- ครอบครัวเดี่ยว ได้แก่
 - (1) ผู้สูงอายุอยู่คนเดียว หรืออาศัยอยู่กับคู่สมรส
 - (2) ผู้สูงอายุอยู่ร่วมกับบุตรหรือหลานที่ไม่มีครอบครัว
 - (3) ผู้สูงอายุอยู่ร่วมกับคู่สมรสและบุตร
 - (4) ผู้สูงอายุอยู่ร่วมกับญาติที่ไม่มีครอบครัว
- ครอบครัวขยาย ได้แก่ ผู้สูงอายุ และ/หรือคู่สมรส และครอบครัวของบุตร หลาน หรือญาติพี่น้องอยู่ร่วมกัน

7. ธรรมเนียมในบ้านที่พักอาศัยในปัจจุบัน (.....)

- เป็นธรรมเนียมของผู้สูงอายุแต่เพียงผู้เดียว
- เป็นธรรมเนียมร่วมกันของผู้สูงอายุและคู่สมรส
- เป็นธรรมเนียมของญาติ
- เป็นธรรมเนียมของบุคคลอื่น เช่น บ้านเช่า เป็นต้น



8. โรคประจำตัว (.....)

- ไม่มีโรคประจำตัว
- มีโรคประจำตัว โปรดระบุ.....



ส่วนที่ 2 แบบประเมินคุณภาพชีวิตไทยแบบรูปภาพ (Pictorial Thai Quality of Life : PTQL)
พัฒนาโดย สุชีรา ภัทรายุทธวรรณ, เขียรชัย งามทิพย์วัฒนา และบัญชา ทิพย์วรรณท์ (2548)

คำแนะนำ : ข้อความและภาพต่อไปนี้ เป็นสิ่งที่คนทั่วไปเคยประสบในชีวิตประจำวัน ซึ่งแต่ละท่านจะมีประสบการณ์หรือความรู้สึกที่แตกต่างกัน ขอให้ท่านเลือกข้อที่ตรงกับความรู้สึกของท่านที่เป็นอยู่ในขณะนี้ โดยทำเครื่องหมาย ✓ ในระดับที่ตรงกับความรู้สึกท่านมากที่สุด คำตอบที่ให้ไม่มีถูกหรือผิด แต่เป็นการสะท้อนความเป็นจริงที่ตรงกับตัวท่านมากที่สุด

1. ด้านร่างกาย (Physical)

1.1 การนอนของฉันทัน		
		
มีปัญหามาก	มีปัญหาบ้างเป็นครั้งคราว	ไม่มีปัญหาเลย

รับรองโดย คณะกรรมการจริยธรรมการวิจัยในคน
คณะแพทยศาสตร์ศิริราชพยาบาล
รหัสโครงการ 289/2550 (EC2)
วันที่รับรอง 10 ก.ย. 2550

APPENDIX B

PARTICIPANT INFORMATION SHEET

เอกสารชี้แจงผู้เข้าร่วมการวิจัย (Participant Information Sheet)

ในเอกสารนี้อาจมีข้อความที่ท่านอ่านแล้วยังไม่เข้าใจ โปรดสอบถามหัวหน้าโครงการวิจัย หรือผู้แทนให้ช่วยอธิบายจนกว่าจะเข้าใจดี ท่านอาจจะขอเอกสารนี้กลับไปอ่านที่บ้านเพื่อปรึกษาหารือกับญาติพี่น้อง เพื่อนสนิท แพทย์ประจำตัวของท่าน หรือแพทย์ท่านอื่น เพื่อช่วยในการตัดสินใจเข้าร่วมการวิจัย

ชื่อโครงการ ปัจจัยคัดสรรที่เกี่ยวข้องกับคุณภาพชีวิตของผู้สูงอายุในเขตกรุงเทพมหานคร

ชื่อผู้วิจัย นายนามินทร์ สวีระสฤยดี

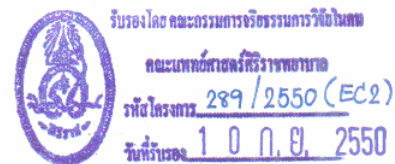
คุณวุฒิ นักศึกษาปริญญาโท สาขาวิชาจิตวิทยาคลินิก ภาควิชาจิตเวชศาสตร์

คณะแพทยศาสตร์ศิริราชพยาบาล มหาวิทยาลัยมหิดล

หมายเลขโทรศัพท์ที่ติดต่อได้ทั้งในและนอกเวลาราชการ 089-793-0302

สถานที่วิจัย ชมรมผู้สูงอายุที่อยู่ในความดูแลของสำนักงานแพทย์ กรุงเทพมหานคร

ผู้ให้ทุน บัณฑิตวิทยาลัย คณะแพทยศาสตร์ศิริราชพยาบาล มหาวิทยาลัยมหิดล



โครงการวิจัยนี้ทำขึ้นเพื่อศึกษาระดับคุณภาพชีวิตของผู้สูงอายุในเขตกรุงเทพมหานคร และศึกษาปัจจัยคัดสรรที่เกี่ยวข้องกับคุณภาพชีวิตของผู้สูงอายุในเขตกรุงเทพมหานคร ซึ่งประโยชน์ที่คาดว่าจะได้รับจากการศึกษานี้คือ ทราบปัจจัยคัดสรรที่เกี่ยวข้องกับคุณภาพชีวิตของผู้สูงอายุ เพื่อใช้เป็นข้อมูลพื้นฐานในการพัฒนาและวางแผนส่งเสริมคุณภาพชีวิตของผู้สูงอายุ ทราบระดับคุณภาพชีวิตของผู้สูงอายุ และค่าเฉลี่ยของคุณภาพชีวิตของผู้สูงอายุในเขตกรุงเทพมหานคร เพื่อนำไปใช้เป็นเกณฑ์เปรียบเทียบคุณภาพชีวิตของผู้สูงอายุ

ท่านได้รับเชิญให้เข้าร่วมการวิจัยนี้ เพราะท่านมีคุณสมบัติตามเกณฑ์การคัดเลือกเข้ากลุ่มวิจัย การวิจัยนี้จะมีผู้เข้าร่วมวิจัยทั้งสิ้น 388 คน หากท่านเข้าร่วมการวิจัย ผู้วิจัยใคร่ขอความร่วมมือจากท่านในการทำแบบสอบถามที่ใช้ในการเก็บรวบรวมข้อมูลวิจัย 1 ชุด ประกอบด้วยข้อคำถามแบบรูปภาพจำนวน 25 ข้อ โดยจะใช้เวลาในการทำแบบทดสอบทั้งสิ้นประมาณ 10-20 นาที

ความเสียดใจที่จะเกิดขึ้นเมื่อเข้าร่วมการวิจัย คือท่านอาจรู้สึกอึดอัดใจไม่สบายใจเกี่ยวกับข้อคำถามบางข้อ ท่านมีสิทธิที่จะไม่ตอบข้อคำถามนั้น ๆ ได้ หรือถ้าท่านรู้สึกเหนื่อย ท่านสามารถพักเป็นระยะสั้น ๆ เมื่อรู้สึกผ่อนคลายแล้วจึงทำต่อ และการทำแบบสอบถามของท่านในครั้งนี้ ข้อมูลต่าง ๆ ทั้งในส่วนประวัติของท่านและผลที่ได้จากการทำแบบสอบถาม จะถูกบันทึกหรือจัดเก็บเป็นฐานข้อมูล โดยท่านไม่ต้องระบุชื่อ และการรายงานสรุปจะออกมาในรูปของภาพรวม ไม่ใช่รายบุคคล ซึ่งกระบวนการดังกล่าวพึงปฏิบัติโดยคำนึงถึงสิทธิส่วนบุคคลของท่าน และหากมีข้อสงสัยเกี่ยวกับการวิจัย ท่านสามารถสอบถามจากผู้วิจัยได้โดยตรงตลอด 24 ชั่วโมง ที่หมายเลขโทรศัพท์ 089-793-0302

หากมีข้อมูลเพิ่มเติมทั้งด้านประโยชน์และโทษที่เกี่ยวข้องกับการวิจัยนี้ ผู้วิจัยจะแจ้งให้ทราบโดยรวดเร็วไม่ปิดบัง

ข้อมูลส่วนตัวของผู้เข้าร่วมการวิจัยจะถูกเก็บรักษาไว้ ไม่เปิดเผยต่อสาธารณะเป็นรายบุคคล แต่จะรายงานผลการวิจัยเป็นข้อมูลส่วนรวม ข้อมูลของผู้เข้าร่วมการวิจัยเป็นรายบุคคล อาจมีคณะบุคคลบางกลุ่มเข้ามาตรวจสอบได้ เช่น ผู้ให้ทุนวิจัย, สถาบัน หรือองค์กรของรัฐที่มีหน้าที่ตรวจสอบ, คณะกรรมการจริยธรรมการวิจัยในคน เป็นต้น



ผู้เข้าร่วมการวิจัยมีสิทธิถอนตัวออกจากโครงการวิจัยเมื่อใดก็ได้ โดยไม่ต้องแจ้งให้ทราบล่วงหน้า และการไม่เข้าร่วมการวิจัยหรือถอนตัวออกจากโครงการวิจัยนี้จะไม่มีผลกระทบต่อบริการที่ท่านเคยได้รับแต่ประการใด

หากท่านได้รับการปฏิบัติที่ไม่ตรงตามที่ได้ระบุไว้ในเอกสารชี้แจงนี้ ท่านจะสามารถแจ้งให้ประธานคณะกรรมการจริยธรรมการวิจัยในคน ทราบได้ที่ สำนักงานคณะกรรมการจริยธรรมการวิจัยในคน ตึกอศุขเวชวิกรม ชั้น 5 โรงพยาบาลศิริราช หมายเลขโทรศัพท์ 0-2419-7000 ต่อ 6405

ข้าพเจ้าได้อ่านรายละเอียดในเอกสารนี้ครบถ้วนแล้ว

ลงชื่อ...../วัน.....

(.....)



รับรองโดย คณะกรรมการจริยธรรมการวิจัยในคน
คณะแพทยศาสตร์ศิริราชพยาบาล
รหัสโครงการ 289 / 2550 (EC2)
วันที่รับรอง 10 ก.ย. 2550

APPENDIX C

INFORM CONSENT

หนังสือแสดงเจตนายินยอมเข้าร่วมการวิจัย

วันที่..... เดือน..... พ.ศ.

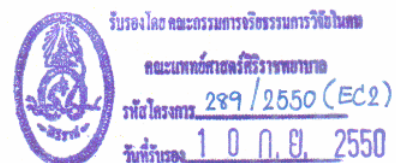
ข้าพเจ้า.....อายุ.....ปี อาศัยอยู่
บ้านเลขที่..... ถนน..... ตำบล.....
อำเภอ..... จังหวัด..... รหัสไปรษณีย์.....
โทรศัพท์.....

ขอแสดงเจตนายินยอมเข้าร่วม โครงการวิจัยเรื่อง “ปัจจัยคัดสรรที่เกี่ยวข้องกับคุณภาพชีวิต
ของผู้สูงอายุในเขตกรุงเทพมหานคร”

โดยข้าพเจ้าได้รับทราบรายละเอียดเกี่ยวกับที่มาและจุดมุ่งหมายในการทำวิจัย รายละเอียด
ขั้นตอนต่าง ๆ ที่จะต้องปฏิบัติหรือได้รับการปฏิบัติ ประโยชน์ที่คาดว่าจะได้รับของการวิจัยและ
ความเสี่ยงที่อาจเกิดขึ้นจากการเข้าร่วมการวิจัย รวมทั้งแนวทางป้องกันและแก้ไขหากเกิดอันตราย
ขึ้น โดยได้อ่านข้อความที่มีรายละเอียดอยู่ในเอกสารชี้แจงผู้เข้าร่วมการวิจัยโดยตลอด อีกทั้งยัง
ได้รับคำอธิบายและตอบข้อสงสัยจากหัวหน้าโครงการวิจัยเป็นที่เรียบร้อยแล้ว

ข้าพเจ้าจึงสมัครใจเข้าร่วมใน โครงการวิจัยนี้ :

หากข้าพเจ้ามีข้อข้องใจเกี่ยวกับขั้นตอนของการวิจัย หรือหากเกิดผลข้างเคียงที่ไม่พึง
ประสงค์จากการวิจัยขึ้นกับข้าพเจ้า ข้าพเจ้าสามารถติดต่อกับ นายนวนินทร์ สวีระสฤษฎ์ หมายเลข
โทรศัพท์ 089-793-0302 ได้ตลอด 24 ชั่วโมง



หากข้าพเจ้าได้รับการปฏิบัติไม่ตรงตามที่ได้ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย ข้าพเจ้าสามารถติดต่อกับประธานคณะกรรมการจริยธรรมการวิจัยในคน หรือผู้แทน ได้ที่สำนักงานคณะกรรมการจริยธรรมการวิจัยในคน ตึกอศุขเวชวิกรม ชั้น 5 โรงพยาบาลศิริราช โทร 0-2419-7000 ต่อ 6405

ข้าพเจ้าได้ทราบถึงสิทธิที่ข้าพเจ้าจะได้รับข้อมูลเพิ่มเติมทั้งทางด้านประโยชน์และโทษจากการเข้าร่วมการวิจัย และสามารถถอนตัวหรืองดเข้าร่วมการวิจัยได้ทุกเมื่อ โดยจะไม่มีผลกระทบต่อ การรับบริการและการรักษาพยาบาลที่ข้าพเจ้าจะได้รับต่อไปในอนาคต ทั้งนี้ยินยอมให้ผู้วิจัยใช้ ข้อมูลส่วนตัวของข้าพเจ้าที่ได้รับจากการวิจัย แต่ไม่ให้เผยแพร่ต่อสาธารณะเป็นรายบุคคล โดยให้ นำเสนอเป็นข้อมูลโดยรวมจากการวิจัยเท่านั้น

ข้าพเจ้าได้เข้าใจข้อความในเอกสารชี้แจงผู้เข้าร่วมการวิจัย และหนังสือแสดงเจตนา ยินยอมนี้โดยตลอดแล้ว จึงลงลายมือชื่อไว้

ลงชื่อ.....ผู้เข้าร่วมการวิจัย/ผู้แทนโดยชอบธรรม

(.....)

วันที่.....

ลงชื่อ.....ผู้ให้ข้อมูลและขอความยินยอม/ผู้วิจัย

(นายณวมินทร์ สวีระสฤกษ์)

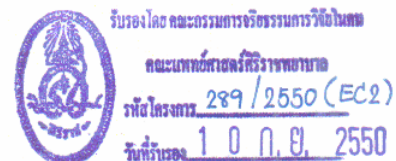
วันที่.....

ในกรณีผู้เข้าร่วมการวิจัยอ่านหนังสือไม่ออกผู้ที่อ่านข้อความทั้งหมดแทนผู้เข้าร่วมการวิจัย คือจึงได้ลงลายมือชื่อไว้เป็นพยาน

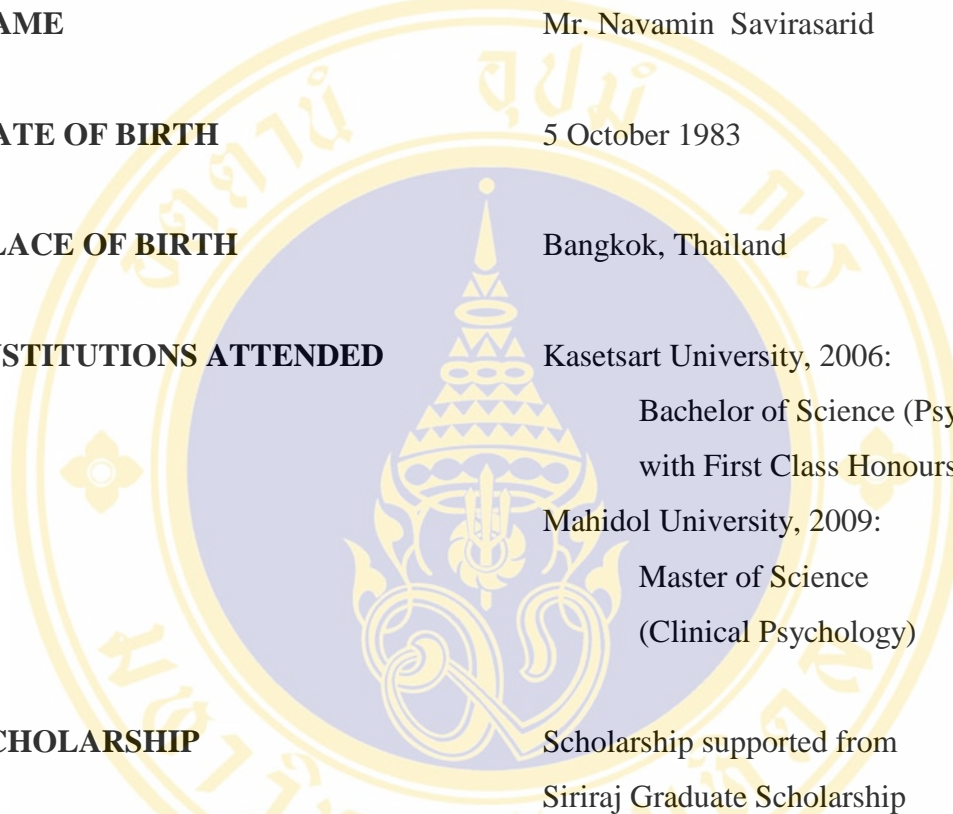
ลงชื่อ.....พยาน

(.....)

วันที่.....



BIOGRAPHY



NAME	Mr. Navamin Savirasarid
DATE OF BIRTH	5 October 1983
PLACE OF BIRTH	Bangkok, Thailand
INSTITUTIONS ATTENDED	Kasetsart University, 2006: Bachelor of Science (Psychology) with First Class Honours Mahidol University, 2009: Master of Science (Clinical Psychology)
SCHOLARSHIP	Scholarship supported from Siriraj Graduate Scholarship