

THE QUALITY OF LIFE WHEN APPROACHING RETIREMENT
AND DURING RETIREMENT IN ROMANIA.
HOW IMPORTANT ARE AGE, MARITAL STATUS,
COMMUNICATION AND SATISFACTION WITHIN THE FAMILY?

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Abstract

It appears that compared to the general population, the approach to quality of life in the elderly is different. With retirement, contact with former colleagues decreases, socialization decreases and the quality of the marital relationship becomes more important. The current study aims to investigate the following areas when approaching retirement and during retirement in Romania: 1) Family communication and satisfaction and the quality of life, 2) the possible correlations between these elements. A cross-sectional study was performed between 2016 and 2017 with 601 patients (55–93 years old). Were used the Life Quality Questionnaire-short form (WHOQOL-BREF) and the Family Communication Scale, Family Satisfaction Scale developed by Olson and colab. The correlation between them and the influence of marital status and age on these scales, using the Kruskal-Wallis test have been analyzed. For items 1 and 2 and for the domains of WHOQOL-BREF, higher mean rank scores were registered for those 55–74 years old, for married people and for those with moderate, high, and very high family satisfaction levels. The participants with moderate and higher levels of communication and family satisfaction said that they were satisfied to a large extent with the quality of their lives. The life quality decreases with age but these age-related inconveniences are better faced by married people who have good communication and satisfaction within the family.

Cuvinte-cheie: calitatea vieții, vârstnici, comunicarea în familie, satisfacția în familie.

Keywords: quality of life; elderly; family communication; family satisfaction.

1. INTRODUCTION

The concept of quality of life (QOL) is used in various areas, such as sociology, psychology, environmental studies, social work, social policy, medicine.

Increasing life expectancy has led to an interest in the concept of quality of life. It appears that compared to the general population, the approach to quality of life in the elderly is different (Netuveli & Blane, 2008).

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With retirement, contact with former colleagues decreases, socialization decreases, and the quality of the marital relationship becomes more important. However, few studies have explored the stress on marriages created by retirement or the ability of couples to adjust to the challenges of diminishing capabilities brought on by the aging process.

In economic and political sciences and social work, quality of life is primarily used to measure comforts and available resources in life (income, household amenities, water consumption, etc.) (Humă, 2015).

Subjective factors, such as happiness and life satisfaction, were included to measure the quality of life (Smith, 2000). Performed in 2003, 2007, 2011 and 2016, the European Quality of Life Survey (EQLS) is a good tool that analyses quality of life in the European Union. The latest report, from 2016, included 28 countries and examined the “subjective well-being, standard of living and aspects of deprivation, care responsibilities and work–life balance; healthcare, long-term care, childcare and other public services; and social insecurity, social exclusion and societal tensions, trust, and participation and community engagement” (Ahrendt *et al.*, 2017).

The choice between ‘quantity of life’ versus ‘quality of life’ in patients undergoing cancer treatment can be considered as the beginning of conceptualization and measurement of the balance between the impact of a treatment and its side-effects (Chaturvedi & Muliya, 2016). In the medical field, QOL has been evaluated in patients suffering from various diseases; this was done using the short form of the life quality measurement questionnaire designed by the World Health Organization (WHOQOL-BREF) to investigate for example schizophrenia (Galuppi, Turola, Nanni, Mazzoni, & Grassi, 2010), 2 diabetes mellitus patients (Raghavendra, Viveki, & Gadgade, 2017); health-related quality of life (HRQOL) on inflammatory bowel disease (Umanskiy & Fichera, 2010), etc.

This concept of wellbeing has led to relative polemics on the definition of QOL because the meanings of health and wellbeing differ from one person to another, depending on the context and their needs. Since then, this concept has become more widely used in defining and measuring quality of life.

In 1996, the World Health Organization Division of Mental Health provided the following definition “*Quality of life is defined as individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns*”. “*Quality of life cannot be equated simply with the terms ‘health status,’ ‘life style,’ ‘life satisfaction,’ ‘mental state’ or ‘well-being’*” (World Health Organization, 1996, pp. 5–6). From the perspective of Huber *et al.* (2011), health is “the ability to adapt and to self-manage”.

When assessing the usefulness of medical intervention for difficult condition, researchers should consider the patients’ feelings, hopes, and worries. At the same time, patients must be understood in the context of their relationships with their families and friends. Features such as work, family, prosperity, spirituality, and health are related to quality of life.

In the elderly, quality of life (QOL) has been researched and mostly evaluated for diseases, particularly in depression, memory problems and activities of daily living function roles (Baernholdt *et al.*, 2012).

Bond & Corne (2004) reported that an individual's quality of life is influenced by his/her expectations regarding old age, health, disease, disability etc. The responsibility for health must be seen at both the individual and collective level as a goal of promoting a human right.

High-quality marriages have a positive effect on physical and emotional well-being (Carr & Springer, 2010). Several instruments have been developed to assess marital satisfaction, some of which are reviewed below. Snyder developed the Dyadic Adjustment Scale (DAS), which was developed by Spanier (1976) to measure the quality of a relationship and the Marital Satisfaction Inventory (MSI).

The positive influence of marital status on the quality of life of patients with various diseases has been studied and is well-known. However, most studies have evaluated the correlation between an unsuccessful marriage and depression and considered the overall measure of life satisfaction (Margelisch *et al.*, 2017).

There are few studies available investigating quality of life, on the one hand, and issues related to the family, such as marital status, family satisfaction and communication, on the other hand. This study investigates precisely these factors in Romania when approaching retirement and during retirement.

2. METHODOLOGY

Design and sampling. This article is based on a quantitative cross-sectional study performed between 2016 and 2017 on 601 patients who were treated at the “Ana Aslan” National Institute of Gerontology and Geriatrics. Sample structure for the variables taken in the analysis is as follows. Age groups (years): 55–64: 37.3% (n=224), 65–74: 45.3% (n=272), 75–79: 11.6 (n=70), equal, greater than 80: 5.8% (n=35). Marital status: married: 52.9% (n=318), widowed: 33.6% (n=202), divorced: 9.2% (n=55), consensual union over 1 year: 3.2% (n=19), unmarried (single): 1.2% (n=7).

Data collection. Depending on the doctor's recommendation and diagnosis, up to 15 blood tests were performed (usual clinical parameters) on the patients. Several questionnaires were administered, including questions on personality, memory, depression, quality of life, and an omnibus-type questionnaire, with 36 items that collected socio-demographic data regarding behaviors harmful for health and opinions and attitudes relevant to the health of the elderly.

This study used the Life Quality Questionnaire-short form developed by the World Health Organization, abbreviated (i.e., WHOQOL-BREF, World Health Organization, Division of Mental Health [1996]), the Family Communication Scale (FCS) developed by Olson & Barnes (1995) and Family Satisfaction Scale (FSS) developed by Olson & Wilson (1995).

WHOQOL-BREF was used based on an agreement received from the WHO, Health Statistics and Information Systems. The Family Communication and Family Satisfaction scales were used under a license received from the developer, from whom the FACES IV Package was purchased. FCS and FSS were validated on the Romanian population (Olson, 2010; Rada, 2019).

The questionnaires were completed in the form of face-to-face interviews with each patient. These interviews were conducted by a psychologist. The response rate was 100%.

Non-cooperative people and individuals with strong auditory or visual sensory deficits, severe cognitive deficits, or disorders accompanied by psychotic elements with serious somatic pathology were excluded from the interviews.

Informed written consent was obtained from each participant at the time of recruitment. The study was approved by the Ethics Commission of the “Francisc I. Rainer” Anthropology Institute of the Romanian Academy (no. 153/01-03-2016).

Instruments, statistical analyses. The WHOQOL-BREF contains a total of 26 questions that are answered on a five-point Likert scale. Q.1, Q.15, response variants: *Very poor, Poor, Neither poor nor good, Good, Very good*; Q.2, Q.16-Q.25, response variants: *Very dissatisfied, Dissatisfied, Neither satisfied nor dissatisfied, Satisfied, Very satisfied*; Q.3-Q.14, response variants: *Not at all, A little, A moderate amount, Very much, An extreme amount*; Q.26 response variants: *Never, Seldom, Quite often, Very often, Always*.

The first and second items are examined separately, and they inquire about the general perception of quality of life and health. The other items evaluate 4 domains: physical health (items 3, 4, 10, 15, 16, 17, 18), psychological (5, 6, 7, 11, 19, 26), social relationships (20, 21, 22), environment (8, 9, 12, 13, 14, 23, 24, 25). Scoring of the WHOQOL-BREF was performed in accordance with the recommendations in the manual, making an automatic syntax in the SPSS program (World Health Organization, 1998; IBM Corp. 2011). In 24 countries, Skevington, Lotfy and O'Connell (2004) found (N=11.830) a relatively good internal consistency (Cronbach's alpha coefficient range, .51 to .89). In Romania, Cronbach's alpha coefficient has been found for the following domains: Physical, Psychological (0.87), Social Relations (0.76), Environment (0.65). The present study from Romania identified that the Cronbach's alpha (α) coefficient of the WHOQOL-BREF was adequate (0.89) for all 26 questions and for three domains: physical health domain (0.79), psychological health domain (0.75), and environmental health domain (0.74). For the social relationship domain, Cronbach's alpha coefficient was poor ($\alpha = 0.51$) but still acceptable for this analysis. None of the items here would substantially affect the reliability if they were deleted, a result that was likely caused by the lack of adaptability of the social relationship scale items to Romanian culture.

FCS and FSS, each with 10 items, belong to the FACES IV Package, which contains also six scales from the Family Adaptability and Cohesion Scale IV

(FACES IV), with 42 items. The answers are given on a five-point Likert scale. FCS had the following response variants: *Strongly Disagree*, *Generally Disagree*, *Undecided*, *Generally Agree*, *Strongly Agree*. FSS had the following response variants: *Very Dissatisfied*, *Somewhat Dissatisfied*, *Generally Satisfied*, *Very Satisfied*, *Extremely Satisfied*. Using the SPSS program, we summed each of the 10 items in the FCS and FSC and provided a total raw score and percentile score for these two scales, in compliance with the manual and the recommendations of the author who created this instrument (Olson, 2010). The present study from Romania identified that the Cronbach's alpha values for Communication and Satisfaction were 0.91 and 0.94, respectively.

The nonparametric Kruskal-Wallis test (K-W) was performed using the SPSS statistical program (IBM Corp., 2011). Due to the lack of normality indicated by Shapiro-Wilk's tests ($p < .05$) the Kruskal-Wallis H test (sometimes also called the "one-way ANOVA on ranks") was used to determine if there are statistically significant differences between age and marital status groups of an independent variable on the continuous dependent variable (scores).

The first, second item and fourth domains of WHOQOL-BREF questionnaire were considered to be dependent variables. Independent variables were considered marital status, family communication and family satisfaction. Marital status included two categories: married (with or without official documents) and divorced, widowed, unmarried.

The current study aims to investigate the following areas: 1) Family Communication and Satisfaction scales and QOL 2) the possible correlations between these elements.

3. RESULTS

Table no.1 shows the levels of FCC and FCS

Table no. 1

Family Communication and Satisfaction for the Whole Sample

Level of FCC and FCS	Percentile Group of Communication		Percentile Group of Satisfaction	
	Frequency	Percent	Frequency	Percent
Very Low	118	19.6	116	19.3
Low	140	23.3	124	20.6
Medium	96	16.0	124	20.6
High	131	21.8	123	20.5
Very High	116	19.3	114	19.0
Total	601	100	601	100

An analysis of the whole sample, according to the WHOQOL-BREF, is shown in Table no. 2.

Table no. 2
Analysis of the Whole Sample, According to the WHOQOL-BREF

First and second items and domains of the WHOQOL-BREF	Response variants	Frequency	Mean	Median
How would you rate your quality of life?	Very poor	1.0	-	-
	Poor	4.5	-	-
	Neither poor nor good	31.6	-	-
	Good	59.6	-	-
	Very good	3.3	-	-
How satisfied are you with your health?	Very dissatisfied	2.0	-	-
	Dissatisfied	13.0	-	-
	Neither satisfied nor dissatisfied	39.6	-	-
	Satisfied	43.3	-	-
	Very satisfied	2.2	-	-
Physical health	-	-	60.92	60.71
Psychological	-	-	65.72	66.67
Social relationship	-	-	59.65	58.33
Environment	-	-	63.55	62.50

For items 1 and 2 and for the domains of the WHOQOL-BREF, higher mean rank scores were registered for younger respondents (55–74 years old) compared to older respondents (75–80 years old) and for married people (with or without official documents) compared to divorced, widowed, and unmarried individuals.

Statistically significant the married participants between 55 and 74 years of age had a better general perception of their quality of life than did unmarried participants, and they described having a better quality of life for the physical health and psychological health domains. Moreover, the married respondents described having a better quality of life compared to the domain of social relationships (Table no. 3).

Table no. 3
WHOQOL-BREF Mean Rank Scores by Age Group and Marital Status

* Married (with or without official documents) ** Divorced, widowed, unmarried

First, second items and domains of WHOQOL-BREF	Age group	Mean Rank	Marital status	Mean Rank
How would you rate your quality of life?	55-64	305.75	Married*	325.65
	65-74	311.35	Divorced, widowed **	269.54
	75-79	277.76	-	[$\chi^2(1)=20.419, p=.010$]
	80+	236.63	-	
		[$\chi^2(3)=9.511, p=.023$]		

First, second items and domains of WHOQOL-BREEF	Age group	Mean Rank	Marital status	Mean Rank
How satisfied are you with your health?	55-64	300.13	Married*	308.25
	65-74	307.45	Divorced, widowed **	291.75
	75-79	314.34	-	$[\chi^2(1)=1.564, p=.211]$
	80+	229.70	-	
		$[\chi^2(3)=7.834, p=.050]$		
Physical health	55-64	328.52	Married*	317.87
	65-74	307.84	Divorced, widowed **	279.46
	75-79	236.90	-	$[\chi^2(1)=7.286, p=.007]$
	80+	199.87	-	
		$[\chi^2(3)=27.620, p=.000]$		
Psychological	55-64	323.03	Married*	331.21
	65-74	311.83	Divorced, widowed **	262.44
	75-79	254.35	-	$[\chi^2(1)=23.413, p=.000]$
	80+	169.16	-	
		$[\chi^2(3)=30.138, p=.000]$		
Social relationship	55-64	307.74	Married*	325.13
	65-74	305.26	Divorced, widowed **	270.20
	75-79	289.64	-	$[\chi^2(1)=15.195, p=.000]$
	80+	247.47	-	
		$[\chi^2(3)=4.233, p=.237]$		
Environment	55-64	306.02	Married*	310.53
	65-74	299.96	Divorced, widowed **	288.83
	75-79	297.49	-	$[\chi^2(1)=2.326, p=.127]$
	80+	283.91	-	
		$[\chi^2(4)=.568, p=.904]$		

For items 1 and 2 and for the domains of the WHOQOL-BREEF, higher mean rank scores were registered for those with family satisfaction at moderate, high, and very high compared with those with very low and low levels of family communication and satisfaction.

In another statistically significant finding, for items 1, 2 and for all domains of the WHOQOL-BREEF (with one exception, the domain of social relationships by family communication), the respondents with moderate, high, and very high levels of family communication and satisfaction reported that they were satisfied, to a large extent, with the quality of their lives (Table no. 4).

Table no. 4

WHOQOL-BREF Mean Rank Scores by Family Communication and Satisfaction

First, second items and domains of WHOQOL-BREF	Family Satisfaction, Communication Level	Family Communication Mean Rank	Family Satisfaction Mean Rank
How would you rate your quality of life?	Very Low	262.02	253.87
	Low	239.93	284.27
	Moderate	283.66	331.17
	High	315.59	346.55
	Very High	347.12	349.73
		$[\chi^2(4) = 29.797, p = .000]$	$[\chi^2(4) = 32.126, p = .000]$
How satisfied are you with your health?	Very Low	242.57	262.90
	Low	263.74	287.91
	Moderate	279.11	320.47
	High	321.86	346.48
	Very High	332.53	334.42
		$[\chi^2(4) = 20.728, p = .000]$	$[\chi^2(4) = 18.943, p = .001]$
Physical health	Very Low	251.48	254.28
	Low	246.09	278.76
	Moderate	282.78	327.70
	High	309.51	354.66
	Very High	360.15	364.72
		$[\chi^2(4) = 26.680, p = .000]$	$[\chi^2(4) = 31.317, p = .000]$
Psychological	Very Low	233.06	230.79
	Low	234.04	277.56
	Moderate	270.46	317.14
	High	318.38	367.67
	Very High	372.32	409.91
		$[\chi^2(4) = 44.276, p = .000]$	$[\chi^2(4) = 62.184, p = .000]$
Social relations	Very Low	186.18	221.04
	Low	219.93	277.90
	Moderate	273.01	345.71
	High	322.11	354.49
	Very High	388.75	403.19
		$[\chi^2(4) = 73.831, p = .006]$	$[\chi^2(4) = 66.661, p = .000]$
Environment	Low	191.96	261.55
	Moderate	290.51	339.41
	High	318.28	373.72
	Very High	370.13	416.32
		$[\chi^2(4) = 55.007, p = .000]$	$[\chi^2(4) = 74.805, p = .000]$

Post hoc analysis. The Kruskal-Wallis H test was statistically significant (i.e., $p < .05$) indicating that the median of at least one group is different from the median of another group. In order to discover which group(s) are different to which

other group(s) we needed to run a post hoc test. Pairwise comparisons were performed using Dunn's procedure with a Bonferroni correction for multiple comparisons (Popa, 2008). This post hoc analysis revealed statistically significant differences in median as follows: For life quality item 1 scores between the 80+ group (236.63) and 65–74 group (311.35) ($p = .035$), but not between any other age group combination. For health scores item 2 between the 80+ group (229.70) and 65–74 group (307.45) ($p = .042$), but not between any other age group combination. For physical domain scores between the 80+ group (199.87) and 65–74 group (307.84) ($p = .003$), 80+ group and 55–64 group (328.52) ($p < .001$), 75–79 group (236.90) and 65–74 group ($p = .013$) and 75–79 group and 55–64 group ($p = .001$) but not between any other age group combination.

For psychological domain scores between the 80+ group (169.16) and 65–74 group (311.83) ($p < .001$), 80+ group and 55–64 group (323.03) ($p < .001$), 75–79 group (236.90) and 55–64 group ($p = .022$) but not between any other age group combination.

IV. DISCUSSION

Over 60% of the participants reported that they have a good and very good quality of life, and approximately 45% said that they are satisfied and very satisfied with their health. These results can be considered to be a good situation for a sample of elderly people hospitalized twice or once a year for treatment. In fact, the analyses below show that the satisfaction regarding their own health was not statistically influenced by age and marital status but was positively influenced by good and very good the FCS and FSS scores.

For all transformed scores in the four domains, there was a mean score and a median score of over 0.58, which indicates a good quality of life. The highest mean and median scores were recorded for the psychological field, indicating that the participants in this sample have the best scores in this domain. The lowest mean and median scores were observed in the social relationship field. The results of this latter aspect should be interpreted with caution, as a result of a poor Cronbach's alpha coefficient.

Communication is an important issue for healthy family relationships. In the Romanian sample investigated in this study, more than half of the participants described having communication at medium, high, or very high levels. To a lesser extent, it was found that family members have several and many concerns about the quality of their communication. Although the percentages at high and low extremes are close, if we consider the family communication at the medium level, we found that in this sample, women and men who reach the third age, or the third and fourth ages, described having a relatively good exchange of information, ideas, thoughts and feelings.

This study identified that more than 60% of the participants described family satisfaction at medium, high, and very high levels. To a lesser extent, it was found that family members are somewhat dissatisfied, very dissatisfied, have some concerns and are concerned about their families.

Although the percentages at the low and high extremes are close, if we consider family satisfaction at the medium level, we can state that women and men in this sample, who reach the third age, or those at the third and fourth ages, described that they felt relatively happy and relatively fulfilled with each other.

Considering the dimensions of FSS i.e., cohesion, flexibility and communication it can be stated that the respondents feel rather cohesive and flexible in communication. This study of a Romanian sample found that the respondents older than 75 years old described having a lower quality of life. This finding aligns with those of other studies.

In an English longitudinal study of over 11,000 respondents (50–100 years of age), with data collected in 1998, 1999, and 2001, Netuveli, Wiggins, Hildon, Montgomery, and Blane (2006) found that the influence of the various factors of the quality of life varied among the age groups. Note that in the present Romanian study, marital status and age did not influence (in a statistically significant manner) the satisfaction of the participants regarding their own health. Health is valued, regardless of age and marital status. Health is valued in a similar manner among those in the last years of middle adulthood (English Oxford Living Dictionaries, 2018) (i.e., 55–64 years old), at the third age (“young old” 65–74), “old” (74–84), and “oldest-old” (85+) (Bunker-Hellmich, 2015).

This Romanian studied sample revealed that the respondents who were divorced, widowed, unmarried described a less good quality of life. This finding aligns with those of other studies. Robards, Evandrou, Falkingham, & Vlachantoni (2012) analyzed the literature and concluded that marital status remains as an important health and mortality predictor.

The Romanian sample of respondents in the last years of the middle age and in the third age revealed that low family satisfaction was associated with the description of a lower quality of life.

Divorce can be regarded as a failure or as a solution to failure. Other variables that influence the psychological stress produced by these two events, such as the age at which these events occur, gender, residence, income, and remarriage, must also be considered.

Grundy & Tomassini (2010) stated that the results of some studies regarding the health benefits of marriage are inconsistent among older people, particularly older women, because they did not consider the effects of marital history. The authors suggest that for later born cohorts, those whose partnership experiences have been less stable and more heterogeneous, the quality of the relationship becomes more important. The present Romanian study included participants in the last years of middle adulthood and at the third age; it clarifies the importance of the quality of the marital relationship for QOL. The general perception of quality of life and satisfaction regarding health were better in the case of the participants with good

and very good family communication and satisfaction. The participants with good and very good family communication and satisfaction demonstrated better QOL levels in the following domains: physical health (i.e., activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, mobility pain and discomfort, sleep and rest, work capacity), psychological domain (i.e., bodily image and appearance, negative feelings, positive feelings, self-esteem, spirituality/religion/personal beliefs, thinking, learning, memory and concentration, and environment domain (i.e., financial resources, freedom, physical safety and security, health and social care [accessibility and quality], home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment (pollution/noise/traffic/climate), transport. QOL in the domain of social relationships (personal relationships, social support and sexual activity) was better described by the participants with good and very good family satisfaction.

Netuveli *et al.* (2006) suggested that confidence in relationships with family and friends and frequent contacts with friends improved quality of life. This finding was also emphasized in our Romanian study. The ability to cope with the problems associated with aging is influenced by the family climate. "Education is important in order to avoid age-related negative stereotypes, both because they have the potential to strengthen the prejudices or discrimination of the elderly, and because they influence the person to develop patterns of behavior, thinking and emotions that confirm that negative stereotype" (Rada, 2018).

In a survey (data collection 2012 and 2014) of 374 continuously married individuals in wave 1 (mean age: 74.2 years, length of marriage: 49.2 years) and 252 in wave 2, Margelisch *et al.* (2017) found an unhappy group and a happy one. The happy group scored higher on all well-being and health outcomes. However, the author showed that the differences between the two values are fading, as psychological resilience and marital strain are very important. This finding is in line with the current Romanian study.

V. CONCLUSION

In the sample of respondents between 55 and 93 years of age who were treated at the Ana Aslan National Institute of Gerontology and Geriatrics, good quality of life has been identified through WHOQOL-BREF, and the psychological domain was the best scored domain; the lowest scored domain was social relationships. Having good perception of one's own health was scored lower. As a result, it is necessary to encourage older people to join Romanian Senior Clubs. They offer useful services, such as recreational spaces (e.g., libraries, club activities and games, including chess, backgammon, cards, and rummy); information on cultural issues, health, religion or other topics of interest to seniors; social and psychological counseling; and occupational therapy etc. These clubs also offer assistance in organizing

celebrations (e.g., birthdays), and they organize visits to museums, exhibitions and other cultural sightseeing, etc.

The women and men in this sample approaching the third age and those at the third and fourth age described they feel relatively happy and relatively fulfilled with one another and that they feel cohesive, flexible and involved in communication.

This Romanian study identified the importance of family relationships in the lives of the elderly, more precisely when approaching retirement and during retirement. Education to encourage open, honest, and warm communication is needed for healthy cohesion and flexibility, as well as for strong relationships, while respecting the boundaries and autonomy of family members.

This study indicates that geriatric doctors and modern family physicians cannot consider only some strict medical parameters; they should consider the person as a whole, as one who can experience various life situations, such as divorce, widowhood, loneliness, unsatisfactory family climate and so on. These situations may lead to somatization, a lower response to treatment, and a decreased quality of life, independent from the biological decline.

It is clear that QOL decreases with age and that these age-related inconveniences are better faced by married people who have good communication and satisfaction within the family.

The current study is useful and original in the following aspects: it fills a gap in the specialized literature concerning the elderly in Romania, and the identified trends may form a basis for public health programs; it is useful to explore the family environment as a factor with implications for QOL, and such implications are a less researched topic. This study represents the first time that family communication and satisfaction dimensions, as defined by Olson & Barnes (1995) are used.

The main limitation of this study is the small sample size, which was unbalanced in structure.

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REZUMAT

Comparativ cu populația generală, abordarea calității vieții la vârstnici este diferită. Odată cu pensionarea, contactul cu foștii colegi scade, socializarea scade, iar calitatea relației conjugale devine mai importantă. Studiul curent își propune să investigheze următoarele aspecte în perioada apropierii pensionării și la pensionare în România: 1) Comunicarea, satisfacția familială și calitatea vieții la vârstnici, 2) corelațiile posibile dintre aceste elemente. Un studiu transversal a fost realizat între 2016 și 2017 pe 601 de pacienți (55–93 de ani). Au fost utilizate Chestionarul de calitate a vieții forma scurtă (WHOQOL-BREF), scalele de comunicare și satisfacție în familie elaborate de Olson și colab. Au fost analizate corelațiile dintre ele și influența stării civile și a vârstei pe aceste scale, folosind testul Kruskal-Wallis. Pentru itemii 1 și 2 și pentru domeniile WHOQOL-BREF, s-au înregistrat scoruri medii mai mari pentru cei de 55–74 de ani, pentru persoanele căsătorite și pentru cei cu un nivel de satisfacție familială moderat, înalt și foarte ridicat. Participanții cu un nivel moderat și mai ridicat de comunicare și satisfacție a familiei au spus că au fost mulțumiți în mare măsură de calitatea vieții lor. Calitatea vieții scade odată cu vârsta, dar aceste inconveniente legate de vârstă sunt mai bine confruntate de persoanele căsătorite care au o bună comunicare și satisfacție în cadrul familiei.