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"Living happily despite having an illness": Perceptions of healthy aging among Korean American, Vietnamese American, and Latino older adults

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ABSTRACT

Background/objective: The growingly diverse aging population presents a challenge for the geriatric workforce, particularly its capacity to effectively respond to the sociocultural and linguistic needs of ethnic minority older adults. Informed by research on the importance of culturally-competent care in reducing racial and ethnic health disparities, this study sought to understand the meaning of healthy aging from the perspectives of Korean American, Vietnamese American, and Latino older adults.

Methods: Interviews were conducted with 30 participants recruited from community-based organizations in Southern California.

Results: Several dimensions emerged in the participants' understanding of healthy aging: (1) having good physical and mental health (2) optimism and acceptance; (3) social connectedness; (4) taking charge of one's health; and (5) independence and self-worth.

Conclusions: Results could inform the development of a culturally-responsive geriatric healthcare system that takes into account older adults' beliefs, preferences, and needs to promote successful aging.

1. Introduction

The nation's burgeoning aging population has implications for our healthcare system's capacity to respond to the sociocultural and linguistic needs of ethnically-diverse older adults (Centers for Disease Control and Prevention, 2013; Ortman, Velkoff, & Hogan, 2014). Americans aged 65 and older comprised 49.2 million (15.2%) of the U.S. population and are expected to double by 2060 (Vincent & Velkoff, 2010). A diversifying proportion of the older adult population are Asian Americans and Latinos, two of the fastest growing groups in the U.S. Between 2010 and 2030, Asian Americans and Latinos aged 65 and older are projected to increase from 1.4 to 4.1 million and 2.8 to 8.6 million, respectively (Vincent & Velkoff, 2010). To promote successful aging for the geriatric population, our healthcare system needs to understand factors that facilitate healthy aging and to effectively strategize healthcare interventions and care coordination efforts (Bryant, Corbett, & Kutner, 2001; Centers for Disease Control and Prevention, 2013).

While Asians and Latinos are among the fastest growing segment of aging Americans, they continue to face significant barriers in healthcare utilization. Compared to non-Hispanic Whites, ethnic minorities have less access to healthcare, receive lower quality care, and have poorer health outcomes (Alliance for Health Reform, 2004; Damron-Rodriguez, Wallace, & Kington, 1995; Nelson & Washington, 2002; Williams & Rucker, 2000). A movement toward a culturally-responsive system of care is one of the mechanisms for addressing inequities in healthcare access and quality (Brach & Fraserirector, 2000). To effectively facilitate patient-provider communication and health-promoting outcomes, our geriatric workforce must better understand and incorporate the diverse beliefs, values, and preferences that influence older adults' health behaviors (Brach & Fraserirector, 2000; Bryant et al., 2001; Nelson & Washington, 2002; Sadarangani & Jun, 2015; Torsch & Ma, 2000; Yee, 1991).

As such, there has been a corresponding increase in the attention to the development of culturally-appropriate care models. For example, Sue, Arrendondo, and McDavis' (1992) cross-cultural counseling

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conceptual framework has been widely used to inform multicultural competency training. The framework asserts that an awareness of the assumptions about human behavior, values, biases, and preconceived notions – among other considerations – is essential to the development of culturally-appropriate intervention strategies and techniques (Sue et al., 1992). These principles align with the tenets that inform person-centered, culturally responsive healthcare for diverse populations (Epstein & Street, 2011). The traditional medicalized conceptualizations of health, which has dominated the healthcare training curriculum, overlooks the relevant sociocultural contexts of aging for ethnic minority older adults (Sadarangani & Jun, 2015; Weerasinghe & Mitchell, 2007). In order to advance person-centered healthcare training, the perspectives of older adults from ethnically-diverse communities must be integrated into culturally responsive training. Therefore, we examined the perspectives and experiences of community members to inform a healthcare system that is more inclusive of, and responsive to, the sociocultural and linguistic needs of older adults from diverse communities.

While increasing attention has been given to eliciting older adults' views on successful or healthy aging (Cho et al., 2015; Depp & Jeste, 2006; Ebrahimi, Wilhelmson, Moore, & Jakobsson, 2012; Nimrod & Ben-Shem, 2015; Phelan, Anderson, LaCroix, & Larson, 2004; Reichstadt, Depp, Palinkas, Jeste, & Jeste, 2007; Reichstadt, Sengupta, Depp, Palinkas, & Jeste, 2010; Tkatch et al., 2017), only a handful of studies have qualitatively shed light on the perspectives of ethnic minority older adults. Across these studies the interconnectedness among physical, mental, and spiritual health – embedded within family, community, and migration contexts – emerged in the older adults' understanding of healthy aging. In one study with immigrant women from Asia and Central America, migration-related stressors of language difficulties, fulfilling family obligations, and discordant family relationships were salient throughout the participants' multidimensional conceptualizations of health (Weerasinghe & Mitchell, 2007). Relatedly, among older Vietnamese-American women, satisfaction with social relationships, a sense of control over one's life, and financial security – in the context of adaptation to life in the United States – were identified as key markers of successful aging (Chu & Leasure, 2010; Yee, 1992). For some Latino older adults, their sense of well-being was closely tied to an ability to take care of the family, as defined by physical mobility and ability to go to work and provide for the family (Tarp, Fore, Nies, & Febles, 2017).

In two studies that compared perceptions of health among Chinese and Chamorros, whereas Chamorro elders linked their health status to the presence or absence of a disease and their impact on one's ability to function and fulfill family roles, Chinese elders emphasized a balance between the yin and yang forces that harmonize elements of their physical and emotional well-being, family functioning, and societal context (Torsch & Ma, 2000). Nonetheless, both groups highlighted shifting health perspectives and practices that integrated both Western and traditional medicine in health maintenance.

To date, relatively little is known about the perceptions, beliefs, and practices related to successful aging among Asian American and Latino older adults. This study adds to the literature by deepening our understanding of Korean American, Vietnamese American, and Latino older adults' perspectives on healthy aging. Findings could inform the development of educational programs for the geriatric workforce and healthcare professionals to deliver optimal care to underserved minority older adults.

2. Methods

This project was part of larger parent project entitled the ‘Geriatric Workforce Enhancement Project (GWEP)” funded by the U.S. Department of Human and Health Services (HHS). The purpose of the parent study was to understand the perspectives of health from specific communities within a catchment area in order to inform the geriatric healthcare curriculum for primary care physicians who care for underserved older adults. We used the purposive sampling strategy to recruit 10 participants from each ethnic group (i.e., Vietnamese American, Korean American, Latino). We conducted 30 interviews with ethnic minority older adults about their perceptions of healthy aging to inform the cultural competency of health care providers – including physicians, nurses, and allied professionals – who serve older adults. The protocol of the parent project was reviewed by the University of California, Irvine's, Institutional Review Board and received a Non-Human Subjects Research determination due to its focus on quality improvement of healthcare services for the geriatric population.

2.1. Participants

One-on-one, semi-structured interviews were conducted with 10 Vietnamese American, 10 Korean American, and 10 Latino older adults recruited from local community centers, senior centers, and federally-qualified health centers (FQHC) in Orange County, Southern California. Participants were eligible if they were 65 years or older. Each interview lasted on average an hour and was conducted in Vietnamese, Korean, and Spanish by bilingual interviewers: a Korean-speaking nursing faculty (JL), a Vietnamese-speaking social work faculty (HN), and Spanish-speaking graduate nursing student and medical resident. Participants received a $25 gift card as a token of appreciation for their participation. We developed an interview guide with questions about participants' perceptions of health and illness, the challenges they experience with aging, and knowledge and utilization of community support.

2.2. Data analyses

Interviews were recorded and then transcribed and simultaneously translated into English by bilingual translators, and cross-checked by nursing faculty (JL) and social work faculty (HN) members. Following a deductive qualitative analytic approach by Braun and Clarke (2006), the lead researchers (HN & JL) developed a coding tree with categories, subcategories and a description for each category – informed by the domains in the interview guide. The researchers then trained four undergraduate students to perform thematic data analysis using Dedoose qualitative software. To ensure consistency in the application of codes, the lead researchers (HN and JL) co-coded the first two interviews with each undergraduate coder. The coding team met and reviewed the initial codes, discussed new codes or modifications based on the initial coding, corrected the initial codes, and updated the coding tree and definitions. Each remaining interview was independently coded by one undergraduate coder. The lead researchers (HN and JL) met weekly with the coders as a team to review the codes, discuss key concepts and salient codes, and clarify questions and codes based on consensus.

3. Results

Table 1 shows the characteristics of the participants. The majority were female ($n = 23$), born outside of the United States, living with a spouse or child ($n = 16$), and living in the United States for over 20 years. Self-rated English proficiency was highest among Korean Americans, followed by Vietnamese American and Latinos. Insured status varied across groups, with all Korean Americans ($n = 10$) and nearly all Vietnamese Americans ($n = 9$) reporting having a health insurance, but only half of Latinos ($n = 5$) were insured.

Several salient dimensions emerged in the participants' conceptualizations of healthy aging: (1) having good physical and mental health; (2) optimism and acceptance; (3) social connectedness; (4) taking charge of one's health; and (5) independence and self-worth.

Table 1
Participant characteristics.

	Vietnamese elders (n = 10)	Korean elders (n = 10)	Latino elders (n = 10)
Age*			
65–70	2	4	4
71–75	5	3	–
76–80	3	3	1
Gender (female)	6	8	9
Living status:			
Alone	2	1	0
With child and spouse	0	0	1
With spouse	2	9	1
With child	2	0	2
with others	2	0	3
Years living in the United States: mean (minimum – maximum)	21 (7–41)	36 (20–51)	30 (17–46)
Having a health insurance	9	10	5
Comorbidity (having more than 2 chronic diseases)	7	6	6
English proficiency (1 = cannot speak English, 5 = excellent)	2.1 (1–3)	2.9 (2–5)	1.8 (1–3)

Education information is only available for Korean group: all Korean participants had high school education or above.

* There was some limited information of age in Latino group though participants did confirm they were aged 65 and older.

3.1. Having good physical and mental health

3.1.1. Having good physical health

Across participant perspectives a defining characteristic of healthy aging is most commonly associated with having good physical health. The men and women explained that it is more than simply "the absence of an illness;" it meant "not suffering" from the debilitating impact of chronic conditions that would hinder one's ability to eat, sleep, and carry out daily routines.

> Illness is when our health declines to the point where we cannot work and live happily. All of our illnesses make us unable to enjoy life fully and affect our daily activities… For seniors, we have high cholesterol, arthritis, high blood pressure, dementia, cancer and ulcers… All of our body parts are affected… If you don't have health, you don't have anything. Vietnamese American participant 1.

The men and women nonetheless understood that illness becomes a fact of life as they age, a sentiment expressed as follows, "Good health means no illness, but who doesn't get sick? Everyone gets some kind of illness." Everyone we interviewed experienced – with varying severity and intensity – one or more of the following health conditions: diabetes, heart disease, high cholesterol, arthritis, memory loss, insomnia, cancer, high blood pressure, and vision and hearing loss. While medication was noted to help participants manage some of the symptoms, the side effects of feeling "really tired," "foggy," and "restless" also disrupted their daily activities.

As such, participants' subjective view of healthy aging highlighted "living happily despite having an illness" because "the number (age) is not what is important." Rather, "Good health… is I feel well about myself, that I am not having pain anywhere, that I sleep well, that I eat well." One Latina participant proudly rejoiced, "I am turning 70, and I still work and still walk well. I still look very well, hear very well." Participants realized that most, if not, all older adults experience some form of health problem, so they felt content as long as their health conditions do not diminish their ability to carry out daily activities. In other words, what matters is the "quality of life over how long you live."

3.2. Having good mental health

Relatedly, having a balanced state of mind emerged as another salient dimension of healthy aging. Respondents articulated the connectedness between mental and physical health, such that, "When I am not feeling well, my mental well-being declines. I feel weak. I don't think positively about the future. I don't eat well, which causes me to feel sick." In addition to the recognition of the link between physical and mental health, participants asserted the greater impact of mental health on aging: "When you are old and you live well and have a healthy life, you live longer," or "As soon as we have good mental health, then we have everything, but not the other way around." Respondents noted that some physically healthy elders may suffer from chronic sadness and worries that compromise their quality of life. One participant explained,

> There is physical health, and there is mental health. To be healthy you must be healthy in both. If your body is not in good health, your mental health might also not be in good health. If your body is not in good health but your mentality is healthy, I think you can overcome your physical illness much faster. Korean American participant 6.

3.2. Optimism and acceptance

The power of optimism and acceptance emerged throughout the participants' narratives as an essential element of healthy aging. Their words of wisdom – such as, "I have accepted my aging," I can "live a happy life even with my illnesses," and I am learning "to live with it" – unveiled a sense of hope and willpower despite the multitude of challenges during old age. One Korean American participant exclaimed, "As you age, emptiness and loneliness can come to you, and nobody can really fill that up completely. I think that is something you have to deal with on your own." Another similarly shared, "Aging is something very beautiful; I feel happy and I accept my aging with pleasure and dignity." An optimistic perspective on aging allowed older adults to reframe declines in health – viewing their illness(s) as a condition within the body and thereby minimizing its impact rather than allowing it to overpower and define their lives. This sentiment was eloquently expressed by the following Latino respondent:

> I would have liked it if I never got any illness, that they (the doctors) would have never discovered what I have, and that I would be completely healthy. However, I will tell you that being a diabetic does not drain me. I accept it. Latino participant 7

Some participants grounded their optimism and acceptance in religion and spirituality. Attending church and staying connected to one's faith strengthened the ability to face the challenges of aging. Spiritual grounding freed them from the anxieties and worries about a future they have yet to discover or have no control over, and allowed them to put their aging process in the hands of a higher being.

> There are many physical changes that we must face when we become older, and how we overcome these changes can affect us, too. We tend to focus only on the physical changes, which cause many people to become sad and depressed. There are people who try to stay happy during this period of their lives… The important part is to know how to stay happy, healthy, and financially independent regardless of the situation/environment and the physical changes that we must face. I think as we wait for God's calling, it is important to prepare for death in a positive way and to stay happy and independent. Korean American participant 6

> I would say that the most important thing would be to not sit down but to keep on going. If for some reason I start to feel sick, I should not just lay there in bed but actually get up and have the willpower to keep going… We should have high hopes, strength, and willpower to keep on going. I believe that that is the principle of success and wellness. What I do is put myself in God's hands, too, so that He

can give me the strength to keep going. Latino participant 4

3.3. Social connectedness

Participants' reflections on the meaning of healthy aging revealed a desire for connectedness with family and friends: they simply yearned for someone to spend time with and to know that they are not alone. It was evident that the presence of social support and socialization promoted a sense of fulfillment and health among the elders, particularly the role of family in enhancing their aging experiences. Some were overjoyed when sharing the things their children do for them, such as "giving money to buy food" or "helping with the monthly rent." One elder expressed that even the smallest gestures from a family member could uplift her spirit:

> When elders grow old, what makes them feel healthier and happier is the support from their family. Children, brothers, and sisters who are happy with you and don't make you feel lonely… To me I like to have many kids and grandkids and talk to them… My son gives me money and buys me food. That makes me happy… and I wouldn't ask for more. Vietnamese American participant 7

Other participants disclosed the negative impact of conflictual relationships within the family (family discordance) or concerns about family members who are struggling with their lives (e.g., finances, children not doing well in school, family members engaging in substance use). One Vietnamese woman shared the struggles she faced and its consequences on her health:

> People are affected by their family's problems, causing them to get sick. My daughter lost her housing and has to raise 5 children on her own. None of her children has a job. I think my daughter has a mild mental illness. My older grandson also has mental illness. He always played with swords and knives and put them on the roof of the house. He was in and out of the jail… He does not have money to live. One's family situation can affect their health. I feel bad for my grandson's situation but I couldn't ask anyone for help… All these problems causes me to have high blood pressure.. even taking medication cannot control it. I was hospitalized recently because my blood pressure was uncontrollable… So yes… when your mental well-being goes down… it is more severe than having a physical illness. Vietnamese American participant 5

For those who were immigrants to the U.S., changes in family structure and living arrangements were identified as contributing to isolation and loneliness during old age. Whereas a household in a country of origin consisted of multiple generations and situated within a communal setting, it was commonplace in the U.S. for participants to live alone and in neighborhoods where everyone remained behind closed doors. A visit from their family members may be infrequent because of work schedule and obligations within their own family. For immigrant elders who do not speak English and are unfamiliar with the public transportation system, spending the days at home, "living alone" or "having no one to talk to" can exacerbate feelings of isolation, loneliness and abandonment. Two participants echoed these sentiments:

> Immigrants, especially elder Asian immigrants, are usually sponsored by their children to come to the U.S. The elders cannot speak the language and experience many challenges as it is, but without transportation… they will feel as if they are living in jail. Korean American participant 3

> People feel sad when they age because they are not being loved. They are not getting attention and not getting any words of comfort. Families take them to a nursing home, which is not bad, but when they leave them there and don't come back to see them, does that person feel happy? And a lot of the times they die of sadness, because there is no one to give them a smile or a word of love and comfort. Latino participant 7

The men and women noted that having a network of friends – particularly those who speak the same language and understand their culture – is essential to healthy aging because "older adults need to socialize with one another," even if it meant having someone to reach out to by phone when leaving the house becomes physically burdensome. Socialization can mitigate the impact of loneliness and isolation for the participants through fostering "friendships and relationships" and helping them feel "alive," particularly with individuals who share their cultural and migration perspectives. For older adults who have lost their spouses or did not have children living nearby, maintaining social connectedness was even more challenging. As such, ethnic specific agencies or churches were identified by some participants as tremendously helpful avenues for promoting healthy aging through socialization.

> Since the day my wife passed away, I felt so empty. My mind could not concentrate on anything. I felt so lost… I had to find other people, seek help from the community. I began to pull members in my (ESL) class to form a group and study. Whenever I met anyone, I greeted and made friends with them. It made me feel better. Vietnamese American participant 4

> Successful aging in the Korean culture means that you have a group of friends who understand your Korean background, and you can communicate with those individuals. For elders, being able to meet and talk to people who understand you and having a lot of friends help enhance the quality of life, which is important in successful aging. Korean American participant 4

3.4. Taking charge of one's health

While aging introduces health problems and challenges to older adults' psychosocial well-being, participants emphasized that healthy aging meant they must make active, conscious decisions to take charge of their health and not succumb to illnesses. Many asserted their commitment to a healthy lifestyle – not smoking, not drinking, exercising, eating a balanced and healthy diet, getting enough sleep, and taking medications as directed – recognizing that their health conditions required strict routines. The following passage echoes the participants' commitment to prioritizing their health that comes with sacrifices and discipline:

> In order to say that a person lived a successful life, one must live a healthy life until they die. To stay healthy, you should not smoke or drink alcohol. We need to avoid anything that can harm our health and exercise. We need to walk or go to the health center to exercise daily, and we also need to watch what we eat. I think that everyone wants to live a healthy life, but it takes a lot of effort to stay healthy. By eating healthy and exercising, we can prevent illness from happening… Eating smaller portions and exercising regularly for 20 to 30 min daily can help. You can walk or do arm and leg exercises at home. This way you can avoid taking any long term medication. Living your life without illness is a successful life… You have to control your own body. Korean American participant 10

According to some men and women, it is simply not enough to practice healthy routines at home; they must also obtain regular checkups with doctors and follow the doctors' guidance. The respondents asserted that healthy aging meant practicing personal responsibility and self-care, by "dedicating their lives to taking care of themselves and doing everything that doctors suggest." Others similarly shared:

> I have to follow a healthy diet. I have to eat salads, chicken, fish, carefully selected fruits because I cannot eat a lot of fruit that is too sweet. No eating bread, no soda. I have to buy everything that is special for my dietary needs, and that is what I am doing. Latino participant 10

> As you get older, it is good to get regular check-ups and visit the doctor when they ask you to come in. Also, I think that if a person is in control and takes care of his or her health by exercising regularly, eating well, and sleeping well, he or she will be able to live a healthier life. If one does not have good health, one cannot do anything. Korean American participant 8

3.5. Independence and self-worth

Participants spoke about a diminishing sense of independence and self-worth that parallel a decline in health and ability to work and live independently as they age. As such, a salient aspect of healthy aging means maintaining one's "independence," "self-worth" and "contributing" rather than "burdening" one's family and community. The men and women overwhelmingly expressed a desire to thrive independently for as long as they could because, "You don't have to bother your children much," or "I don't want to owe people anything." Another similarly echoed the importance of "having control over your life, doing what you like, going where you like, and enjoying your hobbies." There was widespread fear among the respondents that they one day could no longer take care of themselves and would become a "burden" on family members. The following narratives captured the yearning for independence and the fear of losing one's dignity and self-worth during aging:

> I want to continue doing the things that I would normally do, continue doing things like cooking because that is what I enjoy doing… I do not like it when people help me and tell me what I should be doing because that would make me start forgetting things. I want to continue being the person I once was by doing everything I can. I do not want to depend on anyone, not even a son or anyone else. I want to be able to take my medications the way that I should take them… Depending on someone to do things for me would make me feel useless. Latino participant 4

> I don't want to be a burden to my daughter or for her to have to stop working to take care of me. I want God to take care of me, and the day that I become a burden I'd rather be taken away. I wouldn't like my fifteen children to take me to an elderly center. I wouldn't want my daughter to stop going to the park on Saturday with her son because she has to take care of me. I have to have strength, and with the help of God, I don't think it will get to be that bad. Latino participant 9

While the physical ability to work long hours on a job was no longer realistic for many participants, a common conceptualization of healthy aging was tied to "the ability to work." One participant proudly shared, "I live a life with dignity… like right now I am going to work 3 times per week, and I have money to pay my rent…to eat." Such case was the exception, however, as most respondents we interviewed no longer held a job.

Some participants measured their worthiness in their children's personal and professional accomplishments and having the opportunity "to live happily with children and grandchildren" for the rest of their days. These achievements assured the elders that they have fulfilled their role of providing for and ensuring their children' success in life; this purpose seemed never-ending for many respondents. As such, healthy aging not only meant the ability to take care of oneself but the ability to take care of one's family.

> A successful life obviously includes not burdening my children financially. As a parent, I think it is important to be able to help my children until the end. If I cannot help them, I think we need to at the least save up enough money to be able to support ourselves. Korean American participant 5

A common thread in the men's and women's stories are their struggles with financial independence, another indicator of healthy aging that emerged throughout the narratives. While some participants successfully achieved financial security over the years, others arrived in the U.S. without language and skills to enter high-paying jobs: they held low-wage jobs for years and have no substantial savings for old age. These individuals no longer worked and relied on the social welfare programs to support the high cost of living (e.g. housing), living from paycheck to paycheck. The uncertainties of whether the next bills would be paid became a source of stressor for the elders from low-income backgrounds.

Some of the participants also alluded to a civic responsibility to the larger society by making contributions to and not burdening one's community and the social welfare system. One participant felt strongly that, "If you are sick, there is no benefit from living any longer. Being healthy and spending the last years of your life volunteering and sharing your life-long experiences and encouraging others is the way to live." (K8). Another participant expressed her desire to live as a productive, aging member of society:

> Healthy elders do not bother their children and grandkids. They can take care of themselves independently. They make their children feel safe to work and benefit the community and society, make less a burden to the U.S healthcare system and government. Vietnamese American participant 5

4. Discussion

In the context of a growingly diverse aging population, research is needed to enhance our healthcare workforce's capacity and readiness to serve ethnic minority older adults, using health-promoting messages that resonate with their needs and preferences. This study illuminated five interrelated dimensions of healthy aging – (1) having good physical and mental health (2) optimism and acceptance; (3) social connectedness; (4) taking charge of one's health; and (5) independence and self-worth – that could improve culturally-responsive geriatric care for Korean American, Vietnamese American, and Latino older adults. While many participants acknowledged aging as a fact of life accompanied by declining health, they also emphasized the importance of mental wellness, functionality, financial stability, and social relationships that enabled them to provide for and take care of themselves. Nonetheless, the multi-faceted views of healthy aging culminated in one core attribute of healthy aging: participants' independence and self-worth despite growing old. Consistent with previous research, the capacity to adjust and adapt to the challenges of aging remains central to the older adults' conceptualizations of successful aging, extending beyond longevity and absence of disease (Bryant et al., 2001; Ebrahimi et al., 2012; Reichstadt et al., 2007). Findings in this study further reinforce the usefulness of a multidimensional perspective in healthcare communication – one that moves away from the deficit or medicalized view of health and toward a holistic recognition of healthy aging (Carver & Buchanan, 2016; Depp & Jeste, 2006; Douglas, Georgiou, & Westbrook, 2017; Garcés, Scarinci, & Harrison, 2006; Laditka et al., 2009; Montross et al., 2006).

Participants further communicated the importance of taking charge of their health through lifestyle modifications and a commitment to health-promoting behaviors in their daily lives. The older adults understood that while health problems typically accompany old age, their capacity to lead a meaningful, independent, dignified life was the essence of successful aging. If psychosocial and other related contextual factors are integral to healthy aging – and indeed participants expressed an intrinsic motivation to commit to a healthy lifestyle – providers could utilize this knowledge to strategize communication about illness management that link specific factors to health-promoting behaviors and outcomes, thereby incentivizing and empowering older adults to take charge of their health. Research has well-documented the positive impact of effective patient-provider communication on adherence, satisfaction and health outcomes (M. Stewart, 2005; Stewart, 1995). The provision of person-centered care, that appeals to the healthcare needs

and preferences of older adults, could optimize their adherence to treatment recommendations and outcomes (Brach & Fraserirector, 2000; Jongen, McCalman, & Bainbridge, 2018; Kang, Kim, & Kim, 2016; Kleinman, Eisenberg, & Good, 1978).

In this study linguistic and social isolation were commonly experienced among the respondents who felt limited in their ability to initiate and maintain social relationships, thereby diminishing their sense of connectedness to the community and its resources. These migration-related adjustments are commonly reported among immigrants and can indeed negatively impact their overall health (Emami & Torres, 2005; Kim, 1999; Mui & Kang, 2006; Roh, Lee, Lee, Shibusawa, & Yoo, 2015; Tang, Chi, Zhang, & Dong, 2018; Ward et al., 2018). Participants explained that having opportunities to connect with other older adults who speak their language and understand their culture provided a space for social connection, validation, and worthiness – allowing them to form friendships and a network of peers, to seek support for their aging challenges, and to exchange ideas about aging-related resources.

Noteworthy was the participants' identification of integrated care and ethnic-specific agencies as promoting access to health and social services and social support that enhance their psychosocial well-being. Impactful, culturally-sensitive approaches to geriatric care could coordinate efforts between healthcare and social service providers to link older adults with community resources (e.g. socialization opportunities, education classes, volunteerism) to optimize healthy aging. Drawing upon existing resources and tailored programs at these sites would strategically serve to promote more equitable access to healthcare for ethnic minority older adults who frequent these centers for their health needs (Heath, Romero, & Reynolds, 2013; Iglehart & Becerra, 1995).

Several limitations should be considered in the interpretation of the study findings. While the small study sample focused on non-English speaking older Korean Americans, Vietnamese Americans, and Latinos, qualitative findings allow for a deeper understanding of conceptualizations of healthy aging among an underserved segment of older adults in Southern California. Future studies could benefit from a larger and more diversified sample to identify potential variations in the conceptualization of healthy aging by ethnicity, gender, and community contexts. Nonetheless, results inform the development of studies that seek to deepen the healthcare system's understanding of the values and beliefs of older adults from diverse backgrounds to better engage them in treatment and optimize health outcomes.

5. Conclusion

The vulnerability of underserved ethnic minority older adults demand a healthcare system's understanding of and responsiveness to their needs. This study sought to solicit Korean American, Vietnamese American, and Latino older adults' perspectives on successful aging. While there were no striking differences across the perspectives of the three groups, immigrant status was possibly more influential in shaping the study participants' understanding of healthy aging than individual cultural backgrounds. Findings revealed participants' definitions that extended beyond the medicalized view of aging, to one that is characterized by interrelated dimensions of having good physical and mental health, optimism and acceptance, social connectedness, taking charge of one's health, and independence and self-worth. By reframing healthy aging to reflect the older adults' conceptualizations, providers can better promote desired health-promoting behaviors and outcomes. Healthcare providers' provision of culturally-responsive geriatric care must work across systems of integrated care and ethnic-specific agencies to holistically address ethnic minority older adults' needs.

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Declaration of Competing Interest

The authors declare that they have no conflict of interest.

References

Alliance for Health Reform (2004). Closing the gap: Racial and ethnic disparities in healthcare. *Journal of the National Medical Association, 96*(4), 436–440. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2595005/pdf/jnma00304-0044.pdf.

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*(1_suppl), 181–217. https://doi.org/10.1177/1077558700057001S09.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

Bryant, L. L., Corbett, K. K., & Kutner, J. S. (2001). In their own words: A model of healthy aging. *Social Science & Medicine (1982), 53*(7), 927–941. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11522138.

Carver, L. F., & Buchanan, D. (2016). Successful aging: Considering non-biomedical constructs. *Clinical Interventions in Aging, 11*, 1623–1630. https://doi.org/10.2147/CIA.S117202.

Centers for Disease Control and Prevention (2013). *The state of aging and health in America 2013.* Atlanta, GA: Centers for Disease Control and Prevention US Dept of Health and Human Services. Retrieved from https://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf.

Cho, J., Martin, P., Poon, L. W., Jazwinski, S. M., Robert, C. G., Marla, G., ... Davey, A. (2015). Successful aging and subjective well-being among oldest-old adults. *Gerontologist, 55*(1), https://doi.org/10.1093/geront/gnu074.

Chu, N., & Leasure, A. R. (2010). Aging in America: Quality of life among older Vietnamese women immigrants. *Journal of Cultural Diversity, 17*(3), 105–109. Retrieved from http://ucelinks.cdlib.org:8888/sfx_local?sid=google&auinit=GBC&aulast=Nancy+Chu+PhD&atitle=Aging+in+America:+quality+of+life+among+older+vietnamese+women+immigrants&title=Journal+of+Cultural+Diversity&volume=17&issue=3&date=2010&spage=105&issn=1071-5568.

Damron-Rodriguez, J., Wallace, S., & Kington, R. (1995). Service utilization and minority elderly. *Gerontology & Geriatrics Education, 15*(1), 45–64. https://doi.org/10.1300/J021v15n01_05.

Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. *The American Journal of Geriatric Psychiatry, 14*(1), 6–20. https://doi.org/10.1097/01.JGP.0000192501.03069.bc.

Douglas, H., Georgiou, A., & Westbrook, J. (2017). Social participation as an indicator of successful aging: An overview of concepts and their associations with health. *Australian Health Review, 41*(4)https://doi.org/10.1071/AH16038.

Ebrahimi, Z., Wilhelmson, K., Moore, C. D., & Jakobsson, A. (2012). Frail elders' experiences with and perceptions of health. *Qualitative Health Research, 22*(11), 1513–1523. https://doi.org/10.1177/1049732312457246.

Emami, A., & Torres, S. (2005). Making sense of illness: Late-in-life migration as point of departure for elderly Iranian immigrants' explanatory models of illness. *Journal of Immigrant Health, 7*(3), 153–164. https://doi.org/10.1007/s10903-005-3672-y.

Epstein, R. M., & Street, R. L. (2011). The values and value of patient-centered care. *Annals of Family Medicine, 9*(2), 100–103. https://doi.org/10.1370/afm.1239.

Garcés, I. C., Scarinci, I. C., & Harrison, L. (2006). An examination of sociocultural factors associated with health and health care seeking among Latina immigrants. *Journal of Immigrant and Minority Health, 8*(4), 377–385. https://doi.org/10.1007/s10903-006-9008-8.

Heath, B., Romero, W. P., & Reynolds, K. (2013). A review and proposed standard framework for levels of integrated healthcare. Washington, D.C. Retrieved from www.integration.samhsa.gov.

Iglehart, A. P., & Becerra, R. M. (1995). *Social services and the ethnic community.* Boston, MA: Allyn and Bacon.

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: A systematic scoping review. *BMC Health Services Research, 18*(1), 232. https://doi.org/10.1186/s12913-018-3001-5.

Kang, S.-Y., Kim, I., & Kim, W. (2016). Differential patterns of healthcare service use among Chinese and Korean immigrant elders. *Journal of Immigrant and Minority Health, 18*(6), 1455–1461. https://doi.org/10.1007/s10903-015-0297-7.

Kim, O. (1999). Predictors of loneliness in elderly Korean immigrant women living in the United States of America. *Journal of Advanced Nursing, 29*(5), 1082–1088. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10320490.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care. *Annals of Internal Medicine, 88*(2), 251. https://doi.org/10.7326/0003-4819-88-2-251.

Laditka, S. B., Corwin, S. J., Laditka, J. N., Liu, R., Tseng, W., Wu, B., & Ivey, S. L. (2009).

Attitudes about aging well among a diverse group of older Americans: Implications for promoting cognitive health. *The Gerontologist, 49*(S1), S30–S39. https://doi.org/10.1093/geront/gnp084.

Montross, L. P., Depp, C., Daly, J., Reichstadt, J., Golshan, S., Moore, D., & Jeste, D. V. (2006). Correlates of self-rated successful aging among community-dwelling older adults. *The American Journal of Geriatric Psychiatry, 14*(1), 43–51. https://doi.org/10.1097/01.JGP.0000192489.43179.31.

Mui, A. C., & Kang, S.-Y. (2006). Acculturation stress and depression among Asian immigrant elders. *Social Work, 51*(3), 243–255. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17076122.

Nelson, A., & Washington, D. C. (2002). Unequal treatment: Confronting racial and ethnic disparities in health care. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2594273/pdf/jnma00325-0024.pdf.

Nimrod, G., & Ben-Shem, I. (2015). Successful aging as a lifelong process. *Educational Gerontology, 41*(11)https://doi.org/10.1080/03601277.2015.1050904.

Ortman, J. M., Velkoff, V. A., & Hogan, H. (2014). An aging nation: The older population in the United States. Retrieved from https://www.census.gov/prod/2014pubs/p25-1140.pdf.

Phelan, E. A., Anderson, L. A., LaCroix, A. Z., & Larson, E. B. (2004). Older adults' views of "successful aging"—how do they compare with researchers' definitions? *Journal of the American Geriatrics Society, 52*(2), 211–216. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/14728629.

Reichstadt, J., Depp, C. A., Palinkas, L. A., Jeste, D. V., & Jeste, D. V. (2007). Building blocks of successful aging: A focus group study of older adults' perceived contributors to successful aging. *The American Journal of Geriatric Psychiatry, 15*(3), 194–201. https://doi.org/10.1097/JGP.0b013e318030255f.

Reichstadt, J., Sengupta, G., Depp, C. A., Palinkas, L. A., & Jeste, D. V. (2010). Older adults' perspectives on successful aging: Qualitative interviews. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry, 18*(7), 567–575. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20593536.

Roh, S., Lee, Y.-S., Lee, K. H., Shibusawa, T., & Yoo, G. J. (2015). Friends, depressive symptoms, and life satisfaction among older Korean Americans. *Journal of Immigrant and Minority Health, 17*(4), 1091–1097. https://doi.org/10.1007/s10903-014-0021-z.

Sadarangani, T. R., & Jun, J. (2015). Newly arrived elderly immigrants. *Journal of Transcultural Nursing, 26*(2), 110–117. https://doi.org/10.1177/1043659614549074.

Stewart, M. (2005). Reflections on the doctor-patient relationship: From evidence and experience. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners, 55*(519), 793–801. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16212856.

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: A review. *CMAJ: Canadian Medical Association, 152*(9), 1423–1433. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7728691.

Sue, D. W., Arrendondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477–486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x.

Tang, F., Chi, I., Zhang, W., & Dong, X. (2018). Activity engagement and cognitive function: Findings from a community-dwelling U.S. Chinese aging population study. *Gerontology and Geriatric Medicine, 4*. https://doi.org/10.1177/2333721418778180 233372141877818.

Tarp, H. C., Fore, M. E., Nies, M. A., & Febles, C. G. (2017). What does it mean to be healthy? Hispanics in the Southeastern Idaho agricultural industry. *Journal of Immigrant and Minority Health, 19*(5), 1253–1255. https://doi.org/10.1007/s10903-016-0439-6.

Tkatch, R., Musich, S., MacLeod, S., Kraemer, S., Hawkins, K., Wicker, E. R., & Armstrong, D. G. (2017). A qualitative study to examine older adults' perceptions of health: Keys to aging successfully. *Geriatric Nursing, 38*(6), https://doi.org/10.1016/j.gerinurse.2017.02.009.

Torsch, V. L., & Ma, G. X. (2000). Cross-cultural comparison of health perceptions, concerns, and coping strategies among Asian and Pacific Islander American elders. *Qualitative Health Research, 10*(4), 471–489. https://doi.org/10.1177/104973200129118589.

Vincent, G. K., & Velkoff, V. A. (2010). *The next four decades - the older population in the United States: 2010 to 2050. Washing, DC*.

Ward, J. B., Albrecht, S. S., Robinson, W. R., Pence, B. W., Maselko, J., Haan, M. N., & Aiello, A. E. (2018). Neighborhood language isolation and depressive symptoms among elderly U.S. Latinos. *Annals of Epidemiology, 28*(11), 774–782. https://doi.org/10.1016/j.annepidem.2018.08.009.

Weerasinghe, S., & Mitchell, T. (2007). Connection between the meaning of health and interaction with health professionals: Caring for immigrant women. *Health Care for Women International, 28*(4), 309–328. https://doi.org/10.1080/07399330601179794.

Williams, D. R., & Rucker, T. D. (2000). Understanding and addressing racial disparities in health care. *Health Care Financing Review, 21*(4), 75–90. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11481746.

Yee, B. (1992). Markers of successful aging among Vietnamese refugee women. *Women & Therapy, 13*(3), 221–238.

Yee, D. L. (1991). Health care access and advocacy for immigrant and other underserved elders. *Journal of Health Care for the Poor and Underserved, 2*(4), 448–464. https://doi.org/10.1353/hpu.2010.0429.