

Exploring the Links between Social Determinants and Perceptions of Living Well among Aging African Americans in the Arkansas Delta Region: A Qualitative Study

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Studies on aging have often focused on the medical and biological aspects of the aging process. This article presents an alternative perspective by providing a meaningful understanding of living well in an aging population with multiple chronic conditions. Our community-based qualitative study elaborates narratives from aging African Americans living in the Arkansas Delta and their perceptions of the links between social determinants and aging. Using purposeful sampling, we recruited and individually interviewed thirty one study participants, aged 50 years or older, with a self-reported chronic illness diagnosis. We analyzed data using grounded theory methodology. Results indicated that the personal meaning of aging, shaped by an individual's socio-environmental contexts, affects one's perception of living well. Findings highlighted that the personal definition of living well may vary in different stages of chronic conditions. Implications for a comprehensive approach integrating medical, biological, and psychosocial aspects to guide practice and policy are discussed.

Key words: living well, aging, chronic conditions, social determinants, African Americans.

The concept of living well is generally defined as the best achievable state of health and optimum level of functionality regardless of conditions of chronic illness or an individual's present state of disablement (Institute Of Medicine, 2012) in one's own sociocultural contexts. Aging and an increased life expectancy contributes to the prevalence of multiple chronic conditions that often impacts functionality (Elder, 1999; IOM, 2012).

Aging, being a natural process of human development, individuals gradually lose their maximum functional capacity. A large portion of the literature on

aging has often focused on the medical and biological aspects of prolonging life expectancy alone (IOM, 2012). In their research on aging well, previous researchers emphasized the need to study aging in socio-environmental contexts (Braveman & Gottlieb, 2014).

Social determinants in aging describe individual's experiences in social, cultural, and environmental settings and recognize the roles that family, friends, and community members play (Kendall, Foster, Ehrlich, & Chaboyer, 2012; World Health Organization, 2010). The interaction of biomedical and social determinants in aging with multiple chronic conditions is an emerging research topic. Researchers have highlighted our limited understanding on the interactions and perceptions of living well in diverse groups within socio-environmental and cultural contexts (Hawkins, 2005; Hong, Jiying & McCarthy, 2014). Our qualitative study addresses this gap in knowledge and focuses on understanding the interactions and perceptions of living well using a holistic perspective.

This study examines whether social determinants are linked to the perception of living well among aging African Americans, particularly with regard to the socio-environmental and cultural contexts of the rural Arkansas Delta. To learn from participants themselves, the primary investigator (PI) conducted a community-based qualitative case study among aging African Americans with multiple chronic conditions living in the Arkansas Delta.

The perception of living well encompasses dimensions of physical, mental, and social well-being (Lorig, et al., 2006). The physical and mental health conditions that occur in aging, the consequences of chronic conditions which follow different stages of severity and progression, as well as the interactions between aging and social determinants of health are relevant to understanding the perception of living well.

Physical and Mental Health in Aging

Physical health and function depend on the coordinated functioning of bodily organs and physiological systems that allow the aging person to maintain good health. It is well understood that biological factors impact the aging process. The aging process is generally associated with a greater incidence of degenerative, metabolic and chronic diseases (Braveman & Gottlieb, 2014; Greene, 2012). Some individuals may experience a slow decline and live longer with minimal physical or mental impairments (Martin, MacDonald, Margrett, & Poon, 2010; Picard, 2011). Studies found that an active lifestyle, followed by a proper nutritional diet, decreased age-related disease incidence and progression and also contributed towards reducing metabolic risks (Manini, 2010; Picard, 2011; Sattelmair, Pertman, & Forman, 2009).

At the same time, research has also shown that the aging process is not solely determined by the biological factors (Gow, Bielk, & Gerstorf, 2012; Marmot, 2005; Rowe & Kahn, 1998; Ryff & Singer, 2009). These studies suggest that a dynamic interplay of psychosocial and socio-environmental factors, as well as biological factors, determine an individual's success in maintaining quality of life during aging. Although individual differences exist, in general, older people often face physical ailments, psychological stressors related to age-related health issues, and chronic illness such as coronary heart disease and type 2 diabetes

(T2D). An increased level of dependency can also occur as personal losses require reliance on others, making the lack of a social support system detrimental to health. However, research suggests that overall, reasonably high levels of affective well-being and emotional stability can be found in the older population.

Researchers also found that levels of deterioration or improvement are influenced by an individual's dispositional characteristics such as one's coping mechanisms and style of managing challenging situations (Carstensen, Pasupati, Mayr, & Nesselrode, 2000; Kessler & Staudinger, 2009; Scheibe & Carstensen, 2010). Emotional functioning combined with physical ailment may affect an individual's perceptions of the living well concept. An emerging body of studies indicates that protective psychosocial factors, such as the belief in the ability to control one's situation, quality of social support, and self-identity as an important member of society, contribute to the maintenance of emotional and physiological functioning capacity of individuals in the aging process (Braveman & Gottlieb, 2014; Greene, 2012; Lachman & Agrigoroaci, 2010; National Research Council, 2012).

Stages of Chronic Illness and Aging

The course of chronic illnesses and conditions, such as T2D, cancer, and arthritis are progressive, and the course of progression in each is characterized by the levels of clinical severity. Their patterns (i.e., continuous versus intermittent symptoms), and anticipated courses (i.e., stable, fixed deficit versus progressive), may follow a wide spectrum of variations for the aging population. The consequences of living with chronic illness often result in the individual experiencing functional limitations and/or disabilities.

Following the IOM (2012) definition there are three stages to chronic illness. The early-stage of chronic illness is characterized by lower burdens or limited functional changes in an individual's ability to perform daily tasks. From a functional disability or impairment aspect, this stage could relate to diagnosis and the individual's need to follow a self-management or treatment regimen. Symptoms may include for example, pain in case of osteoarthritis or thirst in T2D. In such cases, the duration could be intermittent and not prolonged.

The moderate-stage of illness is characterized by an individual's functional disability or impairment that affects their capability to perform daily tasks. Symptoms often impose functional limitations for example, someone with osteoarthritis may have trouble driving a vehicle or an individual with T2D may have vision problems or require limb amputation. This stage also marks the individual's high self-management needs and an increasing dependence on caregivers. Late-stage illness is characterized by an individual's functional ability being severely impaired. This stage could contribute to rapid progression and be terminal.

Progressive disability or impairment is often associated with the presence of other multiple chronic conditions (MCC) and dependence on caregivers can further impact individual's perception of illness burden. For example, hip surgery in osteoarthritis and dialysis requirements for T2D may cause significant lifestyle changes which at the same time emphasize the need of high self-management efforts with caregivers' continuous support.

The prevalence of MCC increases substantially among adults over age 65, even though the pathways to aging, chronic illness, and MCC are complex and can vary (Cassell, 1983; Lyness et al., 2006; IOM, 2012). The inability to perform daily tasks and interference with usual daily life-style, increases along with an individual's dependence on caregivers (Clark, 2004).

Pickard et al. (2011) document clearly the correlation between the needs of elderly adults and the potential increase of that group in the future. The authors estimated that either institutional or home-based long-term care could increase from the 8 million that it was in 2000 to 19 million in 2050 (p. 247-248). The authors explain that this potential increase in the future could cause even greater issues with not only care but financial support. Pickard et al. (2011), explains that 78 percent of adults who need help with daily living, actually don't receive support through paid programs. Rather, their support is usually provided, almost exclusively by family members and friends (p. 248-249).

Two important issues are noteworthy in the context of perceptions with regard to quality of life and the characteristics related to the stages of chronic illnesses. One, there is no typical pathway describing an individual's experience of illness-progression during early, moderate, or late stages. This progressive trend can be slow, rapid or terminal and an individual's experience of symptoms can be manageable or severe. Second, the variability in rates of progression, even for the same illness and complexity of the occurrence of MCCs, can affect the individual's feelings of disability and functional impairment. This variability in worsening conditions is relevant to the individual's perception of what it means to be independent, how illness can be a burden, and the amount of dependence on caregivers that is sometimes required. The fear of dependence on caregivers can have an emotional affect, which can in turn alter an individual's perception of quality of life.

Social Determinants, Aging, and Living Well

The social determinants of health are broadly defined by the social influences (i.e. how people live, learn, and age) and physical environments (i.e. places where people are born, live, and work) that people experience throughout their lives (WHO, 2010). These determinants are not absolute but can have both influence and impact on health behaviors and conditions.

Previous studies on health and health care found that poverty, living in a disadvantaged neighborhood, access to and availability of health care services or transportation, and the availability of healthy foods in local stores are some specific examples of social determinants that play important roles on health care status for all and particularly to aging population (Borglin, Edberg, & Hallberg, 2005). Experiences of institutional racism, discrimination, and residential segregation are some additional determinants that can influence the experience of seeking formal health care and health-related functions for all (Krieger, 2001; WHO, 2010). The environments in which people live, such as rural versus urban areas, presents different characteristics and those differences can influence transportation, the availability of health care, and the availability of walking facilities.

While the importance of social determinants on health is well recognized, there is very little information regarding the ways these variables interact. For

example, how societal norms and attitudes related to discrimination operate and affect an individual's perception of aging and living well. Studying how these social determinants differ between populations would also provide more meaningful information for future research or policy (Braveman & Gottlieb, 2014).

It is important to recognize that personal goals related to functional capability and the expectations surrounding living well may differ considerably among subgroups of the older population. For example, those who are younger may find it more important to continue working and maintaining the ability to drive while older persons might be more interested in being able to do daily living activities independently and remaining at home.

A Qualitative Community-based Study

The PI conducted a qualitative, community-based study to understand from aging African Americans diagnosed with chronic conditions their perceptions of health and life with chronic illnesses in their own sociocultural contexts. This study was conducted in the Arkansas Delta region. The rural Arkansas Delta in the eastern portion of the state of Arkansas presents distinct social economic characteristics. While 17.2 % of the state's African Americans live in urban areas, 28.6% reside in the Delta (University of Arkansas, 2011). Poverty rates are substantially higher in the Delta. Seven, Arkansas Delta counties have poverty rates of 25% or greater, compared to 18.8% in the state as a whole (Arkansas Department of Health, 2009).

Many differences exist regarding the prevalence of diabetes by race/ethnicity in AR. In 2010, 12.3% of non-Hispanic Blacks had diabetes, compared to 9.3% of non-Hispanic Whites and 8.8% of Hispanics (United Health Foundation, 2011). According to the Centers for Disease Control and Prevention, National Center for Health Statistics (2015), in AR, the number of death rates per 100,000 population for heart disease is 257.2 for African Americans compared to 209.7 of Caucasians and the number of death rates per 100,000 population for diabetes is 52.6 for African Americans compared to 20.9 of Caucasians.

In the AR Delta, type 2 diabetes (T2D) is underreported, and ranked number four among the state's seven health problems with the highest mortality rates for minorities. In 2007, AR's annual rate of newly diagnosed T2D cases among adults 18 years and older was 11.2 per 1,000 people, compared to the national rate of 8.0 (AR Dept. of Health, 2010, p.1). Diabetes is well-recognized as a very underreported cause of death in the state of AR. Only 10–15% of death certificates name diabetes itself, instead diabetic complications like a stroke or heart attack, are stated as the actual cause of death (AR Dept. of Health, 2010, p.25). At the same time, the percentage of total deaths caused by stroke and other cerebrovascular diseases—often complications of diabetes—was 54.7% for Whites and 91.7% for Blacks (AR Dept. of Health, 2010, p.25). Due to these issues, the AR Department of Health Diabetes Prevention and Control Program and the Diabetes Advisory Council have identified diabetes prevention, treatment, and management as priority areas (AR Dept. of Health, 2010, p.25). These particular study participants were all living in rural delta region.

The purpose of this study was to encourage the participants to narrate their

perceptions on aging and health; examples include aging as it relates to spirituality, reliance on professional and familial healthcare providers, reactions to chronic illness diagnoses, as well as experiences related to suffering from chronic conditions (i.e. cardiovascular problems, poor eye sight, and high blood pressure) and often severe complications like kidney failure and lower limb amputations. The Institutional Review Board at the university where the study took place, gave its approval for this community-based study in the AR Delta.

Methods

The PI sought eligible participants with a purposeful sampling method that included several outreach activities and information flyers. The eligibility criteria included: African American men and women who were age 50 years or older, participants had to currently be living in AR Delta, and have self-reported a chronic disease diagnosis. The chronic disease diagnosis criteria included the self-reporting of other chronic illness conditions for a minimum of six months before their interview date (Bhattacharya, 2012a).

In this study, the PI used a narrative approach to gather participant's experiences for two reasons. One, narratives encourage participants to talk about themselves, as they see their life, within their own sociocultural and historical context. Speaking in their own voice and explaining their own experiences makes them feel more comfortable. Listening to the participants' narratives and paying attention to the language they use, the interviewer is able to situate the contexts in which participants place their aging and chronic illness. This process helps enrich to quality of the data gathered. Two, another important reason for this approach is that, for African Americans, storytelling and intergenerational oral histories preserve their collective, culturally specific spiritual practices, values, traditions, and histories (Cosentino, 1998; Liburd, Namageyo, & Jack et al., 2004; Wenzel, 2006).

Having applied a narrative approach to their own studies, researchers found that participant's storytelling helped to improve blood pressure readings among African American patients (Houston et al., 2011) and encouraged cancer-related health promotion behaviors (Hinyard & Kreuter, 2007).

Data Collection

The PI applied a convenience data collection strategy to recruit study participants and used several community outreach initiatives for contacts. These strategies involved two African American community leaders, one male and one female, who presented information about the study during community meetings. The PI created flyers and brochures to describe the study and included a toll-free telephone number to initiate interest for the potential study participants. In addition to the toll free number, the PI and community leaders also made public announcements about the study during informal social gatherings and recorded contact information of prospective participants.

Another African American woman, very active in community organizations and a community advocate, discussed the study at informal community get-togethers and collected the names and telephone numbers of people who were

interested. The PI frequently visited different stores, meeting places, and other locations where flyers were posted and gave further information on the study to any interested passerby.

All data was gathered in 2010, between the months of March and July. Data was collected from study participants via individual open-ended interviews. Individual level data included knowledge about chronic illnesses, self-care practices, social networking and social support, medical insurance, and the emotional stress of chronic illness diagnosis. The narrative approach to data collection fostered trust and self-disclosure among the participants (Padgett, 1998).

Measures

Table 1 outlines the thematic, open-ended, semi-structured guide developed from literature reviews and evidence-based studies for this study's participant interviews. All interviews were face to face, 60 to 90 minutes long, and were conducted by the PI. It should be stressed that the interviewer encouraged the participants to narrate their own life experiences of spirituality, spiritual beliefs, relationship with God, and the role of church in their T2D management.

The interview guide was first field-tested for the appropriateness of its themes and the identification of any additional ones that needed to be covered. This was accomplished through a pilot study with six participants, three women and three men. The principal investigator conducted all of these pilot interviews. During the pilot phase, all themes in the guide were found to be appropriate. Table 1 below shows the list of themes.

Table 1

AGING AND QUALITY OF LIFE AMONG AFRICAN AMERICANS DIAGNOSED
WITH CHRONIC ILLNESS: BROAD THEMES FOR INTERVIEW

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1. Perception of functional capability in aging.
 2. Perception of aging and health.
 3. Experience of aging and satisfaction in life.
 4. Aging as it relates to spirituality and practices.
 5. Health and illness beliefs.
 6. Reliance on chronic illness diagnosis.
 7. Links between social & environmental factors and aging and health.
 8. Role of church in chronic illness and its consequences.
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Sample Description

Thirty one AA adults—15 males and 16 females—participated in this study. Sixty percent of female interviewees and 56% of male interviewees were aged 50 to 64 years, while more than 30% of both genders were aged 65 years or older. Majorities of both the women (75%) and men (67%) attended high school. Twice as many of the women as the men had college degrees. Although the PI intended to also recruit people who had private health plans or who were uninsured, all the men and women participants were on Medicaid/Medicare.

All took prescription medications for T2D and other chronic conditions, which were not familiar to the study participants. Participants were diagnosed with chronic illnesses by laboratory tests in addition to clinical assessments. The length of time between the T2D diagnosis and the date of interview ranged between 2 and 15 years. The PI aspired to have as broad a representation as possible in the sample with regard to medical insurance status, age, occupation, and socioeconomic status (SES). However, the eventual sample lacked such variation in the areas of SES and medical insurance status.

Analysis

This qualitative study used grounded theory approach for data analysis. Grounded theory is a method of inquiry into social processes that can help identify links among participants' life events. As social processes are always changing, the experiences, circumstances, and identities of the study participants may also change. A grounded theory approach allows the researcher to capture the dynamic character of the participants' lives (Strauss & Corbin, 1990). We qualitatively analyzed the data, by applying grounded theory to recognize themes and patterns in the participants' narratives regarding aging and chronic illness-related quality of life changes (Bhattacharya, 2012a, b, c).

The PI and two other researchers together read the transcripts, agreed upon systematic, open coding procedures, and applied these to analyze each participant's stories about T2D self-management adherence and its challenges. Psychological and emotional perceptions of T2D diagnosis were included in the consensus list of codes and concepts that recurred in the participants' narratives regarding T2D self-management.

The team applied an axial coding procedure to explore and identify the conceptual dimensions of the participants' emotions. Then a selective coding procedure was employed to analyze each participant's description of his or her intrinsic and extrinsic motivations and their affects upon that person's quality of life. Next, broad patterns and themes were identified that illuminated links among their psychological and emotional feelings to T2D self-management. The team read and discussed each transcript multiple times, then reframed these links as needed. They ensured intra-coder reliability by comparing each coder's data to what he or she gathered at different points in time throughout the coding process. In each meeting of the coding team, the PI discussed the coding categories with each coder.

Intercoder reliability was also ensured through an iterative process, achieving an agreement of 85% with the final list of codes and definitions. To place the participants' individual experiences in the overall context of African Americans living in the AR Delta, we examined each case on its own and as a part of the entire data set.

Issues of Internal Validity

The PI incorporated three strategies to improve the rigor of this qualitative study; audit trails, triangulation of data, and member checking. Audit trails included the use of journal entries, field notes, and transcribed interviews to determine intra-rater reliability. Triangulation of data involved several forms of

data that the PI and team members utilized to corroborate or challenge findings.

The transcriptions of the interviews, reading of relevant documents and literature, attendance at appropriate conferences, and discussions with African American scholars reflected the determination and commitment to understanding the life experiences of African Americans diagnosed with T2D. In addition, the PI conducted member checking interviews where she asked participants to comment on specific themes arising from their interviews.

Results

The authors present below selected themes that emerged from participants' narratives in the context of chronic illness experiences.

Meaning of Health, Illness and Chronic Illness

Both male and female participants described being healthy as the absence of physical symptoms, such as fever, cough, or upset stomach, and not having to take any medicine. Illness was the presence of symptoms that hinder daily functioning and treatment is to take medicine to bring them back to their definition of healthy. They insisted that as T2D apparently does not have any outward physical symptoms, such as fever or loss of appetite, they do not identify it with illness and accordingly did not feel it was necessary to take medication on a regular basis. A 65 year old female participant voiced this general perception when asked to describe daily activities associated with health and illness.

You know it when you are healthy. I feel happy, want to cook for my family. I clean my house, back yard, I spend good time in the church. Everything is wonderful, thanks to the Lord! I do not want to talk about being sick. Those days, I do not want to do anything. Sometimes I drag myself to cook. Often, I order fried chicken from the deli. When people ask me about my health, I do not want to say I am sick—so depressing.

Chronic Illness Conditions and Consequences

The participant's also revealed knowledge about diabetes-related severe health consequences. Because their illness beliefs did not link any physical symptoms with T2D, the need to change their lifestyle, including diet changes, more physical activities, and taking medicine, was meaningless. A 72 year old male participant explained: "We walk once in a while to go to friends' houses. No one walks in the countryside. Exercises for elderly people? My parents did not do them. They lived 90 years. Old age symptoms caught up obviously." Reflecting on their life experiences, elderly participants considered the doctor's diagnosis and advice to control T2D as a challenge to their African American culture including dietary patterns. A 66 year old, female participant said, "It is my heritage, we eat fast food and fried food. We always had". A similar theme was reflected by the majority of participants regarding their anxiety about caregivers to take care of them if they are incapacitated (Benson, 2014).

Social Historical Contexts and Trust in Medical System

The elderly participants generally maintained some trust in their doctors as indi-

viduals, however, they were skeptical of the medical care system. They revealed their general practices of not seeking treatment from the formal medical system outside the African American community and how herbal medicines and homemade preparations and “grandma’s recipes” took care of them when they were young. They also narrated stories about how herbal and traditional remedies had helped their families to survive and grow since the time of slavery.

The works of anthropologist Hans Baer were crucial to linking belief systems and health practices. In 1992, Baer and Jones further elaborated that spiritualist healers, herbalists, and midwives had a strong influence on the African American population because of their resilience and resistance to segregation. Segregation practices usually forbade medical training and licensing to African Americans, so traditional medicine was often the only way to get medical treatment (Finerman, Williams, & Bennett, 2010).

Recently, the PI learned that elderly African Americans in the Arkansas Delta often chose herbal medicines for relief from breathing problems and swollen feet and to boost personal energy and mood (Bhattacharya, 2012c). Based on their research, Woodward et al. (2010) suggested the need for an integrated health care management and service provision approach. Professional services and informal support working together could readily address any changes that might occur to an older adult’s situation. Such as, the nature of the problem, change in the level of care required, and the stress levels or demands that are placed on their informal caregivers (p.124).

Spirituality and Health Care

All participants asserted that spirituality, a term which was often used interchangeably with religion, is a vital force in their lives and they believed in God as the guide for souls. They explained that their faith in God has helped them cope with the challenges associated with painful experiences during slavery. They attributed their survival as a community, both physically and psychologically, to their faith in God.

Often, the phrase “[The] Lord is my shepherd” was used to describe how they dealt with challenges during their life’s journey. The church was the place they would go to be in a peaceful proximity to God to reflect upon and follow the doctrines of Christianity (Bhattacharya, 2012b). As one participant reflected on God’s control: “But I believe in destiny. I left it to God. When He thinks it is my time to leave this world, I will be ready to go!”

Turner (2011), specifically looked at a single demographic and found that many elderly African American women could be active without actually doing specific exercise routines. Many of these women were active in their church life, such activities often gave them an adequate amount of exercise and also let them participate in something they actually enjoyed (p. 62). So in some ways, this example shows that taking care of one’s self can be less than medically traditional but still effective.

Aging, Chronic Illness, and Health

The participants said that they had observed aging to be generally associated with lower energy, physical challenges, and lower activity levels. They did not

believe these characteristics to be related exclusively with T2D. A 65 year old female participant said, “My sleeping patterns have changed. I stay up late at night and sleep until late morning. I need to go to the bathroom a couple of times at night. But you know, all these are age-related. I am getting old!”

Another female participant, also 65 years old but married spoke of her own physical symptoms while trying to keep up her routine. “Some days, my entire body aches, my feet get swollen. I believe because my body does not pass out water as it did in my younger years. I feel really bad... But I have to get up [and] cook for my family. I eat and then take rest.”

Discussion

Two meaningful issues have emerged to facilitate an understanding of the links between social determinants on aging with multiple chronic conditions and self-perceptions of living well. Firstly, perceptions of living well are shaped by the personal meanings and expectations that an aging individual attaches to their interpretation of living well. As evidenced by the case study participants believed that they weren’t really sick unless there were physical symptoms. In the cases of T2D that showed no outward or obvious symptoms, participants did not link it with chronic illness.

Secondly, social determinants affect the perception of living well by shaping the interactions among aging individual’s in socio-environmental contexts. For example, any outward symptoms that case study participants witness, may be interpreted as just aging.

However, the study participants recognized that the severity of symptoms can become a burden for family and friends who often, are socially expected to care for elderly relatives. A better understanding of how these interpretations and experiences play out with different populations and in different settings has important implications for developing practice interventions and policy formulation on this emerging issue on living well among the aging population. This article offers a holistic approach to understanding the importance of social determinants and the perceptions of living well among aging individuals with chronic illness conditions within their specific environment.

A Model

A preliminary model was developed based on the selected findings gathered from this community-based qualitative study. This presentation illustrates the ways an individual’s social and cultural experiences help shape his or her perception of aging, health and illness beliefs, and chronic illness consequences. The participant’s narratives reflect the dynamic nature of cultural affects, social arrangements, and individual experiences that may vary and influence ones perception of living well.

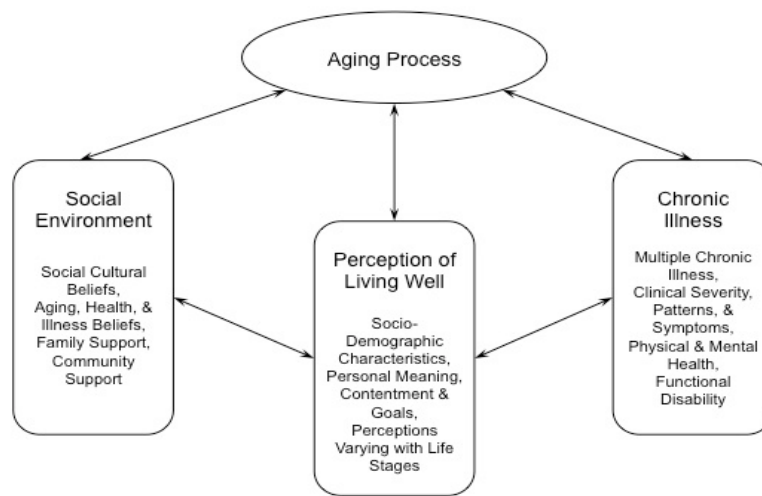


FIGURE 1. Aging with Chronic Illness, Perceptions of Living Well and Social Environments: Influence of Interactions of Selected Factors

Multiple factors affect how people perceive living well. As the above discussion shows, living well with aging and chronic illness can be affected by the nature of the chronic illness as shown by the levels of clinical severity, patterns of symptoms, and anticipated progression (USDHHS, 2012). Furthermore, their interactions and links with others in social, psychological, cultural, and environmental contexts can affect these perceptions as well (Anderson, Goodman, Holtzman, Posner, & Northridge, 2012; Lorig et al., 2006).

Implications for Practice

Social science and health care professionals have increasingly recognized that older people are not a homogeneous group. The education and training of health care professionals needs to use an interdisciplinary perspective when studying or attempting to create new policy for the aging population.

The prevalence of chronic illness conditions is rising among the aging population, showing that variations exist related to the nature and type, length of duration/time, and stage of illness, early, moderate,-and late-stage (IOM, 2012). These variances necessitate an understanding of the medical and biological consequences of the conditions and differential responses to the perceptions of living well. Therefore effective interventions, designed to help individuals with chronic illness conditions live well, need to be examined in the context of biomedical requirements, of an aging person's own preferences, and the level of contentment and sustainability when such interventions are employed.

Rasanathan, Norenhaag, and Valentine (2010), argue that both the rights-based approach and the evidence-base of the social determinants of health are significantly interrelated. Stating the motivation as a reflection of their professional priorities, they desire to understand how rights-based approaches can

combine with equity and become the normal motivating action regarding the social determinants of health (p.53).

Accordingly, the WHO identified three broad themes that could lead to the influence of social determinants in health equality. Bear in mind these are meant to cross global, national, and local levels: 1) the reestablishment of the health sector to address any inequities, with a focus on renewing primary health care, 2) working across sectors to identify and address social determinants and possible equity impacts, and 3) keeping up to date with the changes and the impacts associated with the addressed inequities, plus the impacts of policies and programs (Rasanathan, Norenhag, & Valentine, 2010).

Health care professionals need to be aware of their client's community values and expectations of living well during ageing in order to develop a mutual understanding of what interventions will be effective. Being trained to listen carefully to these individuals will allow medical and social work professionals achieve this goal. The person-in-environment perspective provides a framework to guide social work education and training in this direction as well (Bronfenbrenner, 1994).

This perspective is based on the notion that an individual's behavior needs to be understood within various aspects of that individual's environment (social, political, familial, temporal, spiritual, economic, and physical). A person-in-environment framework thus allows one to frame an individual's behavior, challenges and strengths in a comprehensive context than an approach that focuses solely on biomedical or one that focuses solely on environmental conditions. As was evident in this case study, historical experiences in socio-cultural contexts were critical to studying the meaningful interactions of social determinants with perceptions of living well among African Americans in the Arkansas Delta.

Implications for Policy

The necessity for culturally appropriate policy became evident from using a holistic perspective and a broader interpretation of the concept of social determinants. Biomedical research has developed indicators to describe the changes to physical and mental functioning during the aging process and identified pathways to link aging with the presence of multiple chronic conditions and stages.

Harrison and Dean (2011), caution that much of the national data that policy makers utilize could, in fact, be skewed and argued that surveillance data, limited by particular variables (e.g., disease of interest, age, sex, gender, race/ethnicity), can be easily turned into stigmatizing material that only tells a portion of the story (p.1). They call for a more holistic approach when determining the pathways policy should take regarding healthcare.

Looking at social, structural, and environmental determinants along with those biomedical will provide a greater understanding of the problems that need to be addressed by policy makers.

Although it recognizes the importance of biomedical knowledge and strategies, current policy focuses on shifting towards promoting healthy behaviors and has a greater recognition for developing policy goals in which aging people regard them as relevant (Greene, 2012; Keeler et al., 2010; NRC, 2012).

This study is intended to provide basic guidance for future research meth-

ods by demonstrating in two ways, how these conclusions were reached. One, to learn the individual perceptions of living well from aging African Americans within their familiar sociocultural, environmental, and historical contexts. Two, to pursue an inter-related policy which combines the relevance of biomedical research and psychosocial models. Both biomedical and social work professionals would benefit from identifying social determinants in diverse communities. Social workers, for example, should recognize and carefully explore the heterogeneity between and within diverse groups (Tyler, 2013).

Biomedical and social work professionals need to recognize that health-related behaviors are not the isolated autonomous acts of individuals but instead are socially conditioned, culturally embedded, and economically constrained behavior patterns that affect individual perceptions of living well.

Limitations & Future Research

There are recognize several limitations in this study. First, the study participants were all African Americans living in the rural Arkansas Delta, so they do not represent all African Americans in other rural regions. Rural and urban characteristics are often not similar and for this reason study findings cannot represent African Americans in urban contexts. Also, African Americans are not a homogeneous group. Further, authors documented several methodological limitations. The study participants were recruited using a purposeful sampling method and even with the PI's efforts, the sample was similar in terms of socio-economic status and medical insurance status. In addition, the length of time since the diagnosis of the chronic illness and the interview date can shape the quality of life perception.

It is important to develop future studies with the strengths of this community-based study applying a narrative approach and attention to the limitations of this study. While it is important to acknowledge that a high prevalence of chronic illness among the aging population in the U.S. requires biomedical attention, it is critical to recognize that a holistic perspective on aging individuals integrated with the living well concept will bring personal meaning to aging.

Individual's perceptions of aging, chronic illness, and the meaning of living well are shaped in social and environmental contexts. Perceptions of living well are valued and unique to the person. Research and policy approaches that link aging, chronic illness, and living well are promising initiatives that have the potential for both developing effective interventions and motivating others to research health behavior changes.

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