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Optimizing Tailored Health Promotion for Older Adults: Understanding Their Perspectives on Healthy Living

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Abstract

Objective: This study explores older adults' perspectives on healthy living, and their interactions with professionals regarding healthy living. This perspective is necessary for health professionals when they engage in tailored health promotion in their daily work routines. **Method:** In a qualitative study, 18 semi-structured interviews were carried out with older adults (aged 55-98) living in the Netherlands. The framework analysis method was used to analyze the transcripts. **Results:** Three themes emerged from the data—(a) healthy living: daily routines and staying active, (b) enacting healthy living: accepting and adapting, (c) interaction with health professionals with regard to healthy living: autonomy and reciprocity. **Discussion:** Older adults experience healthy living in a holistic way in which they prefer to live active and independent lives. Health professionals should focus on building an equal relationship of trust and focus on positive health outcomes, such as autonomy and self-sufficiency when communicating about healthy living.

Keywords

older adults, qualitative research, healthy living, health promotion, professional interaction

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Introduction

As people age, many will experience decreased functional capacity, frailty, and dependency on the services of health and social agencies (Abellan van Kan et al., 2008; Ahmed, Mandel, & Fain, 2007; Etman, Burdorf, Van der Cammen, Mackenbach, & Van Lenthe, 2012). Unhealthy behavior may contribute to the acceleration of functional decline in older adults (Hubert, Bloch, Oehlert, & Fries, 2002; Kupper, Schreurs, ten Klooster, Bode, & van Ameijden, 2011).

Adapting positive health-related behavior may reduce and postpone morbidity and improve functioning (Fries, 2001; Hubert et al., 2002). For example, the adoption of a healthy diet after the age of 60 still contributes to quality of life and can add years to life (Knoops et al., 2004; Peel, McClure, & Bartlett, 2005; van Baak & Visscher, 2006; Villareal et al., 2006). Various studies have shown that exercise interventions reduce the risk of falls in older persons and contribute to muscle strength (Province et al., 1995). Even in frail elderly people with an average age of 87 years, high-intensity resistance exercise training is reported to increase muscle strength and size, improve mobility, and

increase levels of physical activity (Fiatarone et al., 1994).

In many Western countries, care for older adults is increasingly offered at home. It is in these everyday practices that health-related behavior should be promoted by health professionals (Jorgensen et al., 2014). Also, social (and health) professionals delivering care services to clients during day-to-day activities play an important part in promoting healthy behavior (Smits, van den Beld, Aartsen, & Schroots, 2014). They know their patients and their home environment and are,

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therefore, in a unique position to perform health promotion in a person-centered manner (Hawley, 2009).

Person-centered care is about partnership and mutual respect between a care user and a care provider. Tailored care is provided in which professionals take a person's own viewpoints (in terms of values, goals, past experiences, and knowledge) into account in decision making (Lutz & Bowers, 2000; Sullivan, 2003). As person-centered care is important to all patient groups, implementation of person-centered care in the training of health professionals is recommended (de Boer, Delnoij, & Rademakers, 2013). Motivational interviewing and shared decision making are useful methods for professionals to accomplish person-centered care when behavior change and choosing between options is needed (Elwyn et al., 2014).

A review by Keleher, Parker, Abdulwadud, and Francis (2009) shows that health promotion by nurses contributes to quality of life in patients. However, health promotion is not always carried out in a person-centered manner (Wagner et al., 2001). Professionals tend to act from their own perspectives and fail to act from, or even understand, the older adults' perspective on healthy living (Derksen et al., 2012). Moreover health care services in general are based on the professionals' appraisal of a person's health care needs rather than taking the users own experiences about their functioning into account (Bate & Robert, 2006).

At the research level, little is known about the perspectives of the older adults themselves concerning preventive care (Behm, Ivanoff, & Ziden, 2013; Butler et al., 2011). More research therefore is needed to elicit older adults' perspectives on healthy living and preventive approaches by professionals.

This study explores the perspectives and views of older adults on healthy living, and their interactions with professionals regarding healthy living. This perspective is necessary for health professionals when they engage in tailored health promotion in their daily work routines.

Method

A qualitative study was conducted to answer the following research question:

Research Question : What are the perspectives and experiences of older adults regarding healthy living and their interactions with professionals regarding healthy living?

Semi-structured 1-hr interviews were carried out with older adults who were living independently or living in sheltered accommodation in two north-eastern towns in the Netherlands, namely Hoogeveen and Zwolle. The Medical Ethical Commission of the VU University Medical Centre Amsterdam confirmed that no examination was needed regarding ethical approval for this study (reference number: 2011-2214, written communication available from the authors). Data collection took place from October until November 2011.

Respondents

We used purposive sampling (Mays & Pope, 1995) to select a wide variety of older adults who received homecare or visited community meetings. Inclusion criteria for participation in this study were (a) participants should receive homecare and/or visit community meetings organized by local community workers, (b) they should be aged 55 years and older, (c) they should reside in one of the selected towns Zwolle or Hoogeveen, and (d) they should be mentally and physically able to participate in a 1-hr interview. The participants were recruited using different strategies. The researchers worked together with homecare professionals and social workers to recruit participants. Special attention was given to the recruitment of non-Dutch older adults, including Moroccans, Turks, and Iraqis because these minority groups are difficult to reach without the right informants. These migrants are all permanent residents in the Netherlands and have equal access to health care services like Dutch residents (Smits et al., 2014). Social workers welcomed us to their group meetings, which were held in community centers. There, we were able to personally invite older migrants to participate in an interview.

Furthermore, we informed registered homecare nurses about the interviews and asked them to recruit older adults who received homecare. The nurses selected clients who met the inclusion criteria and asked those older adults for permission to give the researchers their contact information. After permission was granted, the research team approached these older adults by sending them a letter of invitation. The research assistants (RAs, four female bachelor of nursing students) subsequently phoned the clients who had shown interest in participating and invited them to make an appointment for an interview after having elaborated on the study and having received permission to conduct an interview. Twenty-five older adults were invited for the interviews, meeting the inclusion criteria.

A total of 20 older adults, aged between 55 and 98 years, agreed to participate in this study. Five older adults did not participate. Reasons for non-participation were feeling too old to participate, time restraints, not being interested, and no reason given. Eighteen of the remaining 20 participants completed the interview successfully. Dropout occurred because one of the participants was not at home at the agreed date and time and another participant did not understand the purpose of the interview well enough and could not answer the questions from the questionnaire.

Study Design and Data Collection

The research team (AEMV, MK, CHMS, RAs) worked together in developing the interview guide to elicit rich descriptions of the perceptions and experiences of healthy living. We designed questions to be open ended

and clear. The interview procedure started with questions about healthy living in general (general experience, perceived personal responsibility). Following, participants were asked which of the following behavioral topics they would like to discuss in more detail: exercise, falling, smoking, alcohol, nutrition, mental well-being, and being overweight and/or underweight. Within these topics, questions were asked about meaning of behavior in daily life, persons involved, health information sources, personal aims, activities, tools and prostheses, and perceived support by the health professional. At the start of the study, we aimed to study the interaction between older adults and homecare nurses and/or social professionals especially. However, throughout the interviews, the older adults referred to many different professionals (e.g., general practitioners, dieticians, psychotherapist, medical specialist, psychologists, social workers, homecare nurses). Apparently, these professionals were of significance to the respondents when reflecting on healthy living and aging. Therefore, the term *health professionals* in this study refers to a wide range of professionals that are mentioned by our participants.

Four RAs were trained in qualitative interviewing techniques to conduct interviews with all older adults. Interviews with participants were held at the participants' homes, in a reception room in their sheltered housing accommodation or in a local community center. The interviews were carried out by two RAs (one interviewer and one observer). After the interview, the RAs made field notes based on their observations. The RAs received frequent feedback from the researchers (AEMV and MK) on the quality of their methodological interviewing and their observational notes. Non-Dutch participants were interviewed in their own language if necessary. One participant from Morocco was able to express herself in the Dutch language during the interview. The participants from Turkey and Iraq were interviewed with assistance of an interpreter. The interviewer asked questions in Dutch and the interpreter translated the question directly into the language of the participant. If possible, the participant tried to answer in Dutch, otherwise she spoke in Turkish/Arabic during the interview and the interpreter directly translated her answer in Dutch to the interviewer. The RAs reminded the participants of the confidential nature of the study before they started the actual interview. Participants were asked to sign the informed consent document, and were notified that they could stop participating in the study at any moment.

Analysis

The Framework Method (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Pope, Ziebland, & Mays, 2000; Ritchie & Spencer, 1994) was used to analyze the data, including the following stages:

Stage 1: Familiarization. Members of the research team (AEMV and partly by MK, CHMS, and RAs) listened to

the audio-recorded interviews and read and re-read the interviews that were transcribed verbatim. Observational notes were studied and added as a separate document to the interview in question.

Stage 2: Identifying a thematic framework. The a priori topics from the interview questionnaire concerning healthy living in general were used to develop the analytical framework. For example, topics were healthy living, specific health behavior, and experiences with professionals about healthy living.

Stage 3: Indexing. Transcripts were carefully read and codes were applied to a paraphrase or paragraph. After the coding of the first interviews, agreement was reached on abbreviations of codes. To achieve inter-rater reliability, two RAs coded each interview and were supervised by three researchers (AEMV, MK, and CHMS). The RAs worked in couples and discussed codes and achieved consensus. This resulted in a master code list. Finally, the head researcher (AEMV) re-read all coded interviews and added more codes to the master list. During this stage of the analyzing process, unexpected codes emerging from the data besides the a priori themes were added to the master code list.

Stage 4: Charting. After coding and indexing all relevant data, charts were made to summarize findings. These charts contained distilled summaries of views and experiences of participants of the concerned part of the framework to which they were related.

Stage 5: Mapping and interpreting the data. After summarizing the main findings, they were presented to representatives of participating social institutions and homecare organizations in Zwolle and Hoogeveen. We reported their responses and this process enabled us to further interpret the data. Also, a letter was sent to the participants in which the main results were presented. The research team (AEMV, TLSV, and CHMS) discussed the analytic framework concept regularly. This led to consistent themes that will be presented in the "Results" section.

Results

Eighteen older adults participated in this study, one of whom was male. The average age was 77.8 years (range = 55-98 years). Most participants were of Dutch origin ($n = 14$), others were from Turkey ($n = 2$), Iraq ($n = 1$), and Morocco ($n = 1$), all living as permanent residents in the Netherlands. Table 1 gives an overview of the participant characteristics.

The data presented in this section demonstrate the variety and richness of the narratives obtained during the interviews. From the interview data, three themes (Table 2) emerged concerning the perspectives and experiences of older adults on healthy living and their

Table 1. Sample Characteristics.

| | | |
|---|---|----------|
| N | 18 | |
| Average age | 77.8 | |
| Age range | 55-98 | |
| Sex | 94% female, 6% male | |
| Nationality | 78% Dutch 22% non-Dutch (Turkish, Iraqi, Moroccan) | |
| Former occupation | Housewife (9 of 18), manager, shorthand typist, typist, teacher, seamstress, secretary, domestic worker, social worker, and nurse | |
| Living situation | 83% community dwelling 17% sheltered housing accommodation | |
| Self-reported health and functional state: number of respondents (%) | Diabetes | 8 (44%) |
| | Mobility problems (arthritis, rheumatism) | 7 (39%) |
| | Cardiovascular problems (hypertension, heart failure, high cholesterol, etc.) | 9 (50%) |
| | Falls, balance problems | 9 (50%) |
| | Osteoporosis/bone fractures/artificial hip/leg | 6 (33%) |
| | Vision problems | 4 (22%) |
| | Mental health problems | 5 (28%) |
| | Gastrointestinal diseases | 7 (39%) |
| | Chronic Obstructive Pulmonary Disease / asthma | 2 (11%) |
| | Other (carpal tunnel syndrome, breast cancer survivor, hernia, pain, etc.) | 11 (61%) |
| | Persons using a walker and/or mobility scooter and/or wheelchair | 10 (56%) |

Table 2. Themes and Subthemes From Older Adults ($n = 18$).

| Theme 1. Healthy living: Daily routines and staying active | Theme 2. Enacting healthy living: Accepting and adapting | Theme 3. Interaction with health professionals with regard to healthy living: Autonomy and reciprocity |
|--|--|--|
| Subthemes | | |
| 1. Routine | 1. How older adults experience healthy living | 1. Being autonomous |
| 2. Eating healthy | 2. How older adults cope with changes while aging | 2. Keeping things to yourself |
| 3. Staying active: socially and physically | | 3. Equal relationships—sharing stories |
| 4. Being independent | | 4. A relationship of trust |
| 5. Unhealthy behaviors | | |

interactions with professionals regarding healthy living: (a) healthy living: daily routines and staying active, (b) enacting healthy living: accepting and adapting, and (c) interaction with health professionals with regard to healthy living: autonomy and reciprocity.

Theme 1. Healthy Living: Daily Routines and Staying Active

Participants' views that are reflected in this theme address general views of healthy living that change over time, living with routines, and remaining mentally, physically, and socially active.

In response to our introductory question (i.e., "What comes to your mind when you hear the term healthy living?"), some noticed that they found it a difficult question and did not exactly know how to answer it. Others explained that they felt responsible to live a healthy live

and found it an important subject. Some of the participants did not really care about the subject of healthy living. One of the oldest participants commented that healthy living was not something she had ever thought about when she was younger.

Well, we never used to think about that. That is really a recent concept, but when we were younger we would never think about that. We just lived our lives. I mean that the concept just did not exist. [Interviewer: Healthy living was just not there?] No. I mean it was never, it was, well, everyone just lived the way they wanted to. It was never really talked about. (Dutch woman, aged 98)

Participants talked about healthy living in various ways. Several participants referred to a life structured by daily routines. For example, eating at regular times (breakfast, lunch, and dinner) and going to bed at set times.

Having moments of rest and eating at regular times, structure your life with fixed moments, so, going to bed in time, going out of bed in time, having breakfast in time, and lunch and dinner . . . having routines in life. (Dutch man, aged 85)

Participants also outlined the importance of having a balanced diet, being able to cook their own meals, and eating whatever is served. Dutch participants and migrant participants both recognized that a healthy dinner consists of vegetables, potatoes, and a piece of meat. This is seen as a standard Dutch meal. Some participants talked about alcohol use, in terms of having a glass of wine during dinner or when they have company. They remarked that they used alcoholic drinks with care and with awareness.

Some participants indicated that healthy living meant staying active in daily life. This could mean staying physically active in the broadest sense by walking to their mailbox, or it could mean playing sports, yoga, swimming, and gymnastics for seniors or visiting a physiotherapist regularly. Participants do not always feel like doing exercises but doing it with others and staying fit keeps them motivated. Staying socially active was also mentioned as a way of healthy living. For example, participants noted going out with their children or being in the company of nice people. Older adults enjoy eating with friends and family; they often found it boring to eat alone.

Yes, I drive everywhere with the car. To the children and to the west [of the country] and also to my friend in The Hague. But I need to keep doing that, otherwise I won't be able to anymore. It's the freedom really, isn't it? I go to yoga, and that works out all right. (Dutch woman, aged 83)

As shown in the quotation above, this woman wants to be able to continue driving her car herself to visit family and friends. Other participants also cited things such as "Doing your best" and "still being able to do things yourself," when talking about healthy living. Even "simple" daily activities such as taking a shower without any help were associated with healthy living.

Moreover, doing things for others, gives them the opportunity to be important to others. For example, one of the participants referred to a period in her life when she took care of her husband, who was terminally ill. Being able to take care of him gave her a great feeling of satisfaction. Others noticed that they pay attention to the well-being of others by sending a card or making a phone call.

One participant particularly referred to healthy living as feeling comfortable with oneself. This 64-year-old woman indicated she had gone through many difficulties and pointed out that body and spirit are interconnected.

Theme 2. Enacting Healthy Living: Accepting and Adapting

The second theme that emerged from the data reflects the challenges that participants face in practicing healthy

behavior because of the physical and social changes in aging. Therefore, they have to find ways to accept and adapt to their situation.

Participants mentioned that their sense of taste had decreased and, therefore, they did not enjoy eating as much as when they were younger. Furthermore, certain diseases, such as diabetes, affect their choices of what they can eat. Although most participants still cook for themselves, some cannot manage this anymore.

Being physically active seems to become a bigger challenge when aging, restricting participants' ability to ride a bike or walk longer distances. Accepting that they cannot do these things anymore is not found to be easy for everyone. Some even noted they felt like crying or becoming angry because of their inability to do the things they used to be able to do.

Then I get so angry with myself, and I think, darn! And then I see someone much older than me walking so briskly. Then I think, "Goodness me, I should still be able to do that too! (Dutch woman, aged 70)

Some participants accept their situation and are thankful for the things they still can do:

My mobility is limited, no matter how I look at it, that's just the way it is. Given my age, I can accept it. It is more difficult when you are 25. When my leg was amputated, I was almost 80 and when I realize how many things I can still do at my age, I can only be grateful. (Dutch man, aged 85)

Because many participants had experienced falls, they are more cautious in their movements. Some are afraid to fall and start to use walking aids to feel safer. This is initially experienced as a step backward.

After using a walking frame, the older adults say that they are content using it because it gives them a feeling of independence and safety. The use of a mobility scooter enables them to move greater distances without asking for the help of others or needing to use public transport. Some participants feel ashamed of sitting in a wheelchair. However, if that is the only way to go for a walk, it seems a price they eventually are willing to pay.

Many participants feel lonely at certain times because their loved ones have passed away. They also miss children or friends who live far away; this is especially significant for migrant participants. Some experience tension and stress, which affects their sleep. Even though participants would like to stay socially active, not all of them go out in the evenings. They mention that they are afraid of being robbed and for that reason they do not want to go out or open the door (if they do not know who is coming) in the evening.

Theme 3. Interaction With Health Professionals With Regard to Healthy Living: Autonomy and Reciprocity

The third theme is about the experiences of older adults about their interaction with health professionals

regarding healthy living. From their perspective, they prefer to be autonomous and reciprocal trust is of importance when interacting with health professionals.

Participants repeatedly stated that they do not feel the need to talk about healthy living with homecare professionals, and they do not want more support from them in this aspect. They want to figure things out for themselves and be self-sufficient. They feel awful when they ask for more support, as illustrated by the following quote:

And I know what I'm allowed to do. Yes, I do many forbidden things of which I have to suffer the consequences of in the evening . . . then I think "well, at least I did it myself!" It is very difficult when you have been able to do everything yourself, and then have to ask; Will you do this for me? Will you do that for me? That is terrible. (Dutch woman, aged 77)

Another example illustrates the importance of being autonomous. One of the older adults from Morocco (55 years old) knows smoking is unhealthy but she calls it her only friend. She wants to stop one day, but not now. When others talk about this unhealthy behavior, that is fine with her but they will not make her stop. Her views on healthy living and smoking are illustrated by the following quote:

I'm thinking deeply about going to my doctor and telling him: I want to stop. That is at the back of my mind. That, that is what I would do. But I wouldn't do it because of people telling me to stop smoking. (Moroccan woman, aged 55)

Furthermore, participants want to keep things to themselves. They want to keep things to themselves because of various reasons. For example, an older woman (94) who has diabetes and needs to limit her sugar intake indicated that she did not take too much notice of the doctors' advice, eating cookies between meals. She would not tell the nurse about this but kept it to herself.

Also, participants do not want to bother others with their health-related problems, because they do not want to be regarded as a grumbler. Others mention that they do not want to talk about their own health because that makes them feel worse.

Well . . . we never talk about that. We never talk about my health. There are so many other topics that are more important than my health. . . . The more you talk about it (one's health), the worse it makes you feel [laughs]. (Dutch woman, aged 98)

Participants indicated that they rather talk about other things in life that they thought were more important, such as personal relationships, clothing advice, and the pregnancy of the homecare nurse. Participants also appreciated being able to talk about the loss of their partner or

about family concerns. Participants experience support and feel less lonely when they can talk about such things with their homecare professional.

They also listen to the stories of the homecare professionals and feel involved in their lives. Furthermore, when they feel they can do something for another, they gain a sense of being of importance to others.

Providing help is much nicer than asking for it. (Dutch man, aged 85)

Once participants get to know a health care professional for a longer time, they feel at ease with them. This enables the older adults to build a relationship of trust. With a familiar professional, participants talk more easily about healthy living. For example, they talk about health-related topics with the domestic worker whom they have often known for many years. Still participants prefer that the initiative to talk about healthy living should come from the health professional.

Discussion

In this study, we explored older adults' perspectives on healthy living and their experience of interaction with health professionals regarding this topic. Three themes emerged from the interview data. In the first theme, participants describe healthy living as living their lives with daily routines and staying socially, physically, and mentally active. The second theme is about enacting healthy living: accepting and adapting. While aging, many older adults have to come to terms with various physical, social, and mental limitations. It is not easy to accept and to adapt to these new circumstances for everyone. Older adults try to find a balance between what they still want to do, and how they can achieve it. The third theme shows participants' views on their interaction with health professionals with regard to healthy living: autonomy and reciprocity. Talking about healthy living with health professionals is not something older adults often do. They prefer to sort things out for themselves and talk about other, more important things than their health. If they do talk about healthy living, they prefer to talk to a familiar professional whom they trust.

The holistic views of older adults are in line with the multidimensional perspective on aging, in which aging is not only a biological process but also an interaction of social and psychological domains of functioning (Steverink, 2014). When performing tailored health promotion in a person-centered manner, health professionals should be aware of these holistic views and take these into account.

As older adults try to stay active, they also have to deal with a growing number of limitations. The process of accepting and adapting to these new circumstances, as shown in our second theme, is described by other qualitative studies as a part of successful aging. Older adults need to come to terms with a new situation and

use adaptation and coping strategies to age successfully (Reichstadt, Depp, Palinkas, Folsom, & Jeste, 2007; Romo et al., 2013). Health and social professionals may take the definition of health as “the ability to adapt and to self-manage” rather than a focus on complete physical, social and mental well-being as described by Huber et al. (2011) and by the philosophic vision of Canguilhem (1989) into consideration. Moreover, they may take into account their clients’ holistic and multidimensional views on health as described in this study.

The findings from our third theme about the interactions with health professionals with regard to healthy living reveal different aspects. One finding was that older adults rather not talk about their health status because that would only make them feel worse. This is in line with a study on falls prevention advice, which shows that older adults do not constantly want to be confronted with their limitations (Yardley, Donovan-Hall, Francis, & Todd, 2006).

Another finding from our study shows that a relationship of trust between the older adult and their caregiver enhances opportunities to talk about healthy living. This is in line with studies that show that patients find it important that caregivers are personally interested in them, are reliable, honest, and easy to get along with (Bensing, Rimondini, & Visser, 2013; Custers, Westerhof, Kuin, Gerritsen, & Riksen-Walraven, 2012; Glass, Teaster, Roberto, & Brossoie, 2005). This explains that participants in our study talk with their domestic worker about healthy living. Because this is often a person they have known for a longer time.

Moreover, this study shows that older adults prefer to have relationships on a basis of equality. Also, they want to be important to others, including the homecare professionals whom they see regularly. This aligns with outcomes of focus groups on successful aging that have shown that being useful to others and to society, is considered a prominent aspect of successful aging (Reichstadt et al., 2007).

Our findings have important implications for practice. Professionals should learn to use a person-centered holistic frame when approaching older adults concerning aging in a healthy way. Methods such as shared decision making and motivational interviewing take personal views and considerations into account and are, therefore, suitable (Elwyn et al., 2014; Oshima Lee & Emanuel, 2013; Stacey et al., 2012). Such methods are important because they presuppose a relationship based on equality, which is of major importance in approaching older adults. Messages focusing on positive goals might be more acceptable and effective than advice on prevention of negative health effects. Professionals may adopt a strategy of promoting the ability to stay self-sufficient as a motivator for healthy aging in engaging in person-centered care (Hawley, 2009; Yardley et al., 2006).

Older adults tend to avoid discussing issues regarding healthy living with their care professionals. Thus,

professionals do not only need to be trained to act from a patient’s perspective but also need to become acquainted with concepts of healthy living as perceived by older persons, which will very likely differ from the (young) professional.

Strengths and Limitations

This study gives a voice to older adults and what they think healthy living is about. This is as important to health professionals as it is to researchers in this particular field to deliver and design tailored care (Bensing et al., 2013).

The data presented in this study showed the variety and richness of the narratives obtained during the interviews. However, the target group of our study consisted of mainly women. Therefore, the richness of our data concerning older men is limited. Also, the number of migrant participants in our sample is rather small. Cultural differences might play a large role in their perceptions about healthy living, so research is needed to examine views of multiple groups on healthy living.

Conclusion

Older adults experience healthy living as living their lives actively and autonomously. When aging, it is a challenge to accept and adapt to new circumstances. Reciprocal trust is found of importance when interacting with health professionals. Health professionals therefore should focus on building an equal relationship of trust and focus on positive health outcomes, such as autonomy and self-sufficiency when communicating about healthy living.

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References

- Abellan van Kan, G., Rolland, Y., Bergman, H., Morley, J. E., Kritchevsky, S. B., & Vellas, B. (2008). The I.A.N.A Task Force on frailty assessment of older people in clinical practice. *Journal of Nutrition, Health & Aging, 12*, 29-37.
- Ahmed, N., Mandel, R., & Fain, M. J. (2007). Frailty: An emerging geriatric syndrome. *American Journal of Medicine, 120*, 748-753.
- Bate, P., & Robert, G. (2006). Experience-based design: From redesigning the system around the patient to co-designing services with the patient. *Quality & Safety in Health Care, 15*, 307-310.
- Behm, L., Ivanoff, S. D., & Ziden, L. (2013). Preventive home visits and health-experiences among very old people. *BMC Public Health, 13*, Article 378.
- Bensing, J., Rimondini, M., & Visser, A. (2013). What patients want. *Patient Education and Counseling, 90*, 287-290.
- Butler, M., Talley, K. M. C., Burns, R., Ripley, A., Rothman, A., Johnson, P., . . . Kane, R. L. (2011). *Values of older adults related to primary and secondary prevention: Evidence synthesis*. Rockville, MD: Agency for Healthcare Research and Quality.
- Canguilhem, G. (1989). *The normal and the pathological* (G. R. Fawcett, Translation in collaboration R. S. Cohen). New York, NY: Zone Books.
- Custers, A. F. J., Westerhof, G. J., Kuin, Y., Gerritsen, D. L., & Riksen-Walraven, J. M. (2012). Relatedness, autonomy, and competence in the caring relationship: The perspective of nursing home residents. *Journal of Aging Studies, 26*, 319-326.
- de Boer, D., Delnoij, D., & Rademakers, J. (2013). The importance of patient-centered care for various patient groups. *Patient Education and Counseling, 90*, 405-410.
- Derksen, R. E., Brink-Melis, W. J., Westerman, M. J., Dam, J. J., Seidell, J. C., & Visscher, T. L. (2012). A local consensus process making use of focus groups to enhance the implementation of a national integrated health care standard on obesity care. *Family Practice, 29*(Suppl. 1), i177-i184.
- Elwyn, G., Dehlendorf, C., Epstein, R. M., Marrin, K., White, J., & Frosch, D. L. (2014). Shared decision making and motivational interviewing: Achieving patient-centered care across the spectrum of health care problems. *Annals of Family Medicine, 12*, 270-275.
- Etman, A., Burdorf, A., Van der Cammen, T. J., Mackenbach, J. P., & Van Lenthe, F. J. (2012). Socio-demographic determinants of worsening in frailty among community-dwelling older people in 11 European countries. *Journal of Epidemiology & Community Health, 66*, 1116-1121.
- Fiatarone, M. A., O'Neill, E. F., Ryan, N. D., Clements, K. M., Solares, G. R., Nelson, M. E., . . . Evans, W. J. (1994). Exercise training and nutritional supplementation for physical frailty in very elderly people. *New England Journal of Medicine, 330*, 1769-1775.
- Fries, J. F. (2001). Aging, cumulative disability, and the compression of morbidity. *Comprehensive Therapy, 27*, 322-329.
- Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*, Article 117.
- Glass, A. P., Teaster, P. B., Roberto, K. A., & Brossoie, N. (2005). Elderly and disabled waiver services: Important dimensions of personal care from the client's perspective. *Home Health Care Services Quarterly, 24*(3), 59-77.
- Hawley, H. (2009). Older adults' perspectives on home exercise after falls rehabilitation: Understanding the importance of promoting healthy, active ageing. *Health Education Journal, 68*, 207-218.
- Huber, M., Knottnerus, J. A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D., . . . Smid, H. (2011). How should we define health? *British Medical Journal, 343*, d4163.
- Hubert, H. B., Bloch, D. A., Oehlert, J. W., & Fries, J. F. (2002). Lifestyle habits and compression of morbidity. *Journal of Gerontology, Series A: Biological Sciences & Medical Sciences, 57*, M347-M351.
- Jorgensen, T., Jacobsen, R. K., Toft, U., Aadahl, M., Glumer, C., & Pisinger, C. (2014). Effect of screening and lifestyle counselling on incidence of ischaemic heart disease in general population: Inter99 randomised trial. *British Medical Journal, 348*, g3617.
- Keleher, H., Parker, R., Abdulwadud, O., & Francis, K. (2009). Systematic review of the effectiveness of primary care nursing. *International Journal of Nursing Practice, 15*, 16-24.
- Knoops, K. T., de Groot, L. C., Kromhout, D., Perrin, A. E., Moreiras-Varela, O., Menotti, A., & van Staveren, W. A. (2004). Mediterranean diet, lifestyle factors, and 10-year mortality in elderly European men and women: The HALE project. *Journal of the American Medical Association, 292*, 1433-1439.
- Kupper, N. M., Schreurs, H., ten Klooster, P. M., Bode, C., & van Ameijden, E. J. C. (2011). Prevention for elderly people: Demand-oriented or problem-oriented? *Health Policy, 102*, 96-103.
- Lutz, B. J., & Bowers, B. J. (2000). Patient-centered care: Understanding its interpretation and implementation in health care. *Scholarly Inquiry for Nursing Practice, 14*, 165-183; discussion 183-167.
- Mays, N., & Pope, C. (1995). Qualitative research: Rigour and qualitative research. *British Medical Journal, 311*(6997), 109-112.
- Oshima Lee, E., & Emanuel, E. J. (2013). Shared decision making to improve care and reduce costs. *New England Journal of Medicine, 368*, 6-8.
- Peel, N. M., McClure, R. J., & Bartlett, H. P. (2005). Behavioral determinants of healthy aging. *American Journal of Preventive Medicine, 28*, 298-304.
- Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care. Analysing qualitative data. *British Medical Journal, 320*(7227), 114-116.
- Province, M. A., Hadley, E. C., Hornbrook, M. C., Lipsitz, L. A., Miller, J. P., Mulrow, C. D., . . . Wolf, S. L. (1995). The effects of exercise on falls in elderly patients. A pre-planned meta-analysis of the FICSIT trials. Frailty and Injuries: Cooperative Studies of Intervention Techniques. *Journal of the American Medical Association, 273*, 1341-1347.
- Reichstadt, J., Depp, C. A., Palinkas, L. A., Folsom, D. P., & Jeste, D. V. (2007). Building blocks of successful aging: A focus group study of older adults' perceived contributors to successful aging. *American Journal of Geriatric Psychiatry, 15*, 194-201.

- Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analyzing qualitative data* (pp. 173-194). London and New York: Routledge.
- Romo, R. D., Wallhagen, M. I., Yourman, L., Yeung, C. C., Eng, C., Micco, G., . . . Smith, A. K. (2013). Perceptions of successful aging among diverse elders with late-life disability. *Gerontologist, 53*, 939-949.
- Smits, C. H., van den Beld, H. K., Aartsen, M. J., & Schroots, J. J. (2014). Aging in the Netherlands: State of the art and science. *Gerontologist, 54*, 335-343.
- Stacey, D., Kryworuchko, J., Bennett, C., Murray, M. A., Mullan, S., & Légaré, F. (2012). Decision coaching to prepare patients for making health decisions: A systematic review of decision coaching in trials of patient decision aids. *Medical Decision Making, 32*(3), E22-E33.
- Steverink, N. (2014). Successful development and ageing: Theory and intervention. In N. A. Pachana & K. Laidlaw (Eds.), *The Oxford handbook of clinical geropsychology* (pp. 84-103). Oxford: Oxford University Press.
- Sullivan, M. (2003). The new subjective medicine: Taking the patient's point of view on health care and health. *Social Science & Medicine, 56*, 1595-1604.
- van Baak, M. A., & Visscher, T. L. (2006). Public health success in recent decades may be in danger if lifestyles of the elderly are neglected. *American Journal of Clinical Nutrition, 84*, 1257-1258.
- Villareal, D. T., Miller, B. V., Banks, M., Fontana, L., Sinacore, D. R., & Klein, S. (2006). Effect of lifestyle intervention on metabolic coronary heart disease risk factors in obese older adults. *American Journal of Clinical Nutrition, 84*, 1317-1323.
- Wagner, E. H., Austin, B. T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence into action. *Health Affairs, 20*(6), 64-78.
- Yardley, L., Donovan-Hall, M., Francis, K., & Todd, C. (2006). Older people's views of advice about falls prevention: A qualitative study. *Health Education Research, 21*, 508-517.