The lived experience of older migrants with mild cognitive impairment

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Abstract

"We do not remember days; we remember moments. The richness of life lies in memories we have forgotten."

Cesare Pavese, The Burning Brand: Diaries, 1935–1950.

Mild cognitive impairment (MCI) is recognized worldwide as a serious health issue and a grey area between intact cognitive abilities and mild impairment. MCI is often referred to as the stage between normal ageing and early cognitive decline.
This study aimed to grasp the meaning of the lived experience of older migrants with MCI. The goal was twofold: first, to build a deep understanding of what it means for older migrants to live with MCI and, secondly, to learn from their stories of moments of their lives when their cognition began to deteriorate. Older migrants with MCI have multifaceted stories to share, which is essential for gerontology professionals to recognize and learn lessons from these experiences. Many may have varying levels of insight into their cognitive function and can recall specific moments of such experiences.

Hermeneutic phenomenology was used to explore older migrants' lived experiences of MCI in Aotearoa, New Zealand, which is based on the philosophical foundations of the 20th-century philosopher Martin Heidegger [1889–1976]. By networking with professionals from public services, non-governmental organisations, and community organisations, I connected with older migrants from various countries of origin. After recruitment, primary data were electronically and manually analyzed to inform participants' lived experience with MCI. This research presents the findings from 13 women and two men aged 56–83 years who live in the Auckland community. Their data was crafted into stories with a hermeneutic perspective, divided into four chapters: being thrown into distressing events, being connected with others, forgetting every day, and knowing how to make sense of MCI.

Reflecting on the findings reveals the stress and long-term effects of MCI on older migrants' health and well-being and uncovers their strategy to make sense of living with MCI. MCI is sometimes perceived as a typical ageing problem. Still, some older migrants and their relatives feel differently, highlighting the need for more help, support, education and understanding of this condition. Family trauma, relationship complications, retirement problems, physical health problems, social isolation, and acculturation, are shown to affect the memory of older migrants. Their stories also reveal that socialization, prayer, and interaction with different cultural groups are crucial to keeping their memory supple. Lack of cultural awareness, and stigma concerning MCI contribute to embarrassment or frustration and fear of living with MCI. The stories of older migrants showed how they grasped memory problems and identified their self-management strategies to improve their health and memory.

Dedication

I devote this doctoral thesis to my late grandparents, father, mother and uncle for my upbringing, kindness, and support from my native country of Mauritius. You did not live long enough to see me graduate with this degree, but your presence was still there with me and will stay in my thoughts forever in my academic journey. Thank you very much for empowering me to achieve my dream and for everything I could do in the future with this research. Thank you for your sacrifices and investments in me since I was born and for your continued moral support. I am dedicated to you for being my parents and mentor. Dad, you could not afford higher education in your time, but you once told me, “A little learning is a dangerous thing; you should always seek more knowledge”. Since then, I have always pursued this motto and have kept studying. I have explored what I feel passionate about: older people with cognitive problems that several of our relatives have experienced. I hope my mother and father will be happy with my achievements today.

Acknowledgements

First, I am grateful to all my participants. I am thankful to them for sharing their stories and experiences on issues close to their feelings. It was a considerable experience to spend many hours listening to their stories in their homes or community centres. I am privileged to share their stories with the world to capture moments of their lived experience with their memory problems. Many viewed the discussions with me to express their experience about memory loss as a privilege and were grateful that understanding MCI could help others understand what it feels like to live with this condition.

I profoundly appreciate my supervisors, Professor Stephen Neville, and Dr Rachel Macdiarmid. I also acknowledge my two former supervisors, Professor Valerie Wright St-Clair, and Dr Jed Montayre, who supported me in the initial stages of the study. It was an honour to be supervised by you. Your confidence in my abilities in this thesis has never diminished. When I needed you, you always gave me constructive support and suggestions to guide me on this long journey. I am grateful for you sharing all your wisdom, knowledge, and expertise. Thank you for your patience, directions, and positivity over the last five years. I thank Associate Professor Crystal Yap for convening the oral examination and my two external examiners, Associate Professor Maree Bernoth and Associate Professor Julia Slark, for their insightful commentary and feedback to help me refine this thesis.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which, to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: Ray Jauny **Dated:** 30/7/22

Chapter One: Introduction

"Ma te rongo, kamōhio, Ma te mōhio; ka mārama; Mate mārama, ka mātau, Ma te mātau ka ora".

Through resonance comes cognizance; through awareness comes understanding; through understanding comes knowledge; through knowledge comes life and well-being.

(Tautoko Services, 2020).

In recent decades, life expectancy has risen around the world. Based on the United Nations (UN) figures (2019), by 2050, one in six people will be 65 years old and over, up from one in 11 in 2019. While it is generally accepted that the population's increasing longevity is a human success story, not all older people necessarily enjoy good health (World Health Organisation [WHO], 2020a). People with mild cognitive impairment (MCI) have a higher risk of dementia and die earlier than the general population (Wattmo et al., 2014). MCI contributes to the loss of independence and is an obstacle to treatment concordance, resulting in high care costs and reduced quality of life (Diaz-Venegas et al., 2017; Nikmat et al., 2015).

It is widely accepted that MCI is a complex state of memory decline that includes forgetfulness, reduced thinking skills, language expression, and decision-making severe enough for a person to notice something wrong (National Institute on Aging [NIA], 2020). The older migrant population of Aotearoa New Zealand, is diverse, reflecting many years of resettlement from various countries (Ministry of Social Development [MSD], 2008). Some studies have shown that older migrants showed poorer cognitive function than non-migrants, while others showed no link between migration and cognitive problems (Xue et al., 2017). However, higher levels of acculturation have been associated with better cognitive function performance in older migrants (WHO, 2020a). Although life expectancy amongst this group is high (MOH, 2013), many are prone to health complications, particularly memory problems (MOH, 2014). In fact, MCI is a well-known psychological health problem affecting an all-age population worldwide (Petersen, 2016) and a concern in Aotearoa New Zealand.

This chapter presents the context of this study, highlighting the issue of the lived experience of MCI in the older migrant demographic of Auckland, New Zealand. I outline the personal and academic justifications that led me to this study. I detail the definition of an older person and an older migrant. The demographic population of Aotearoa New Zealand is outlined. The explanation of what MCI is, its relevance to older migrants, background strategies, and Aotearoa New Zealand policies are detailed. The different types of MCI, their historical context, prevalence and how MCI progresses are outlined.

The story that brought me here

Before starting this study, I brainstormed the idea of seniors with cognitive problems with my supervisors. My goal was to use my mental health background to understand older people with dementia better. However, after this discussion, reading existing literature, and talking to gerontology professionals and seniors, I identified MCI as a more practical choice. MCI and its distinctiveness as a health topic were worth studying because of a paucity of research using phenomenology as the methodology and its relevance to older migrants in Aotearoa New Zealand. There was a knowledge gap of older migrants experiencing MCI, and more research would benefit this population, gerontologists, academics, and other stakeholders. I was also acquainted with MCI because it resonates strongly with my encounter with similar conditions experienced by family members.

My professional career spans 25 years in inpatient and community mental health settings in London and Aotearoa New Zealand. In this role, I worked extensively with older people referred to secondary services to seek further assistance in managing their deteriorating cognition. As a community psychiatric nurse, I specialized in assessing and treating people with mild to severe cognitive problems. I have dealt with referrals from various older ethnic migrant groups in Auckland. When considering this gerontological study, I was strongly influenced by my experience working with some older migrants with MCI. Through this study, I hoped to improve the lives of older migrants with MCI by better understanding the condition, raising awareness, and reducing the knowledge gap.

My academic, professional, and personal journey has taught me valuable lessons about MCI and working with older migrants. My experience was a key contributing factor in choosing my research topic because of the personal stories I have learned from older migrants, their understanding of the meaning of memory loss, and my reflection on how best to help or support them. Studying the lived experience of older migrants with MCI is aided by the fact that they can sometimes recall long-term and short-term events. They can contribute meaningful stories about how MCI affects their lives. Hence, after a discussion with my supervisors, we identified a specific need to address the lived experience of older migrants with MCI. Given the heterogeneous nature of older migrants, this study allows the voices of this vulnerable group to be heard and the knowledge of their experience to be shared with others. Learning from their lived experience will help them with care and treatment and inform stakeholders about providing and designing services to meet their needs.

Personal connection

Besides professional connections to this topic, I have personal family ties to the issue of MCI. Most of my extended family live in Mauritius, my birthplace. Both my mother and father died of physical health problems. My father died of leukemia at age 63 in 2001, and my mother died of renal carcinoma at age 74 in 2019. Neither of them had experienced cognitive problems. They were prone to occasional forgetfulness and difficulty recalling certain things because of their comorbidity, but other close family members had MCI.

My own family last visited one of my uncles and aunt in 2014 in Mauritius. My uncle had no sons, and as his eldest nephew, I became like a son and was very close to him. After my uncle’s retirement, he became physically weaker, and his memory deteriorated. During my visits, I asked him, “Do you know who else is here?” pointing toward my four-year-old son. Though he had not seen my son since birth, he immediately recognized who he was. Despite his physical frailty and experiencing MCI, I was pleasantly surprised to see how his long-term memory had remained intact. The second surprise came when he told me my son’s face reminded him of his brother (my father had died five years earlier). This conversation was in Mauritian Creole, the language of Mauritius. Then he asked my son in English, “How are you? Are you well?” I had never heard him speak English and assumed he could not because he had never been to high school. He said more about his memory loss but recalled past events and routines, such as prayer and how it reconnected him spiritually. This experience taught me how the long-term memory of someone with MCI could remain intact despite experiencing memory problems. I learned not to make assumptions about stereotyping someone with MCI.

My aunt also experienced memory problems on a daily basis, forgetting routine tasks, taking different medications she needed, and often getting lost when she went to the local shops. I remember her family's struggles to manage her cognitive problems. Unfortunately, her health deteriorated further, and she was admitted to an aged-residential care facility and died a year later. Sadly, my uncle and aunt had memory issues of different severities and other comorbidities. I reflected upon how their condition affected them and our entire family. While talking to my extended family about prognosis, grief, and continued psychological support, I discussed factors contributing to MCI and how best to support them based on professional experience with similar cases. Experiencing someone close to me with MCI led me to reflect on their health and safety, health education needs, stigma, care and treatment, and consideration for aged-residential care when cognition deteriorates substantially, and how they cannot look after themselves appropriately.

Upon returning to Aotearoa New Zealand, I was eager to learn about MCI and further my postgraduate study. I was still doing my master’s degree and endeavoured to understand the experience of people with MCI, and research on this topic became an important milestone for my doctoral journey. I was keen to communicate how and in what ways the findings could be helpful to help others. At the same time, this topic would raise awareness of the importance of family support, education and understanding MCI. I then discussed ideas with my colleagues, supervisors, and older migrants in my practice. MCI does not discriminate, and I learnt that it could affect anyone regardless of gender, socio-cultural, ethnic, or economic background.

The academic connection

I gained further insight into the phenomenon of cognitive deterioration through my master’s degree research on the assessment and treatment of delirium in aged-residential care facilities (Jauny & Parson, 2017). Delirium is associated with cognition problems, particularly autonomic dysfunction, motor dysfunction, homeostatic failure, reduced awareness, inability to focus, and distraction (Jauny & Parson, 2017; Wass et al., 2008). Understanding how a medical problem can affect older people's cognitive function became an area of interest after a delirium episode. Memory problems are not necessarily permanent; many will recover after treating the underlying cause (Dillon et al., 2013). Moreover, I understood that other physical, psychological, and social problems could contribute to MCI. Cognition can be affected by age-related brain changes, from myocardial infarction and traumatic brain injury to mood disorders and the diseases like Alzheimer's disease [AD] (NIA, 2020). My aim is that research findings will help older migrants with MCI by adding to the body of knowledge and influencing practice policy. Two years later, upon completing my master's degree, I enrolled in a doctoral study on the lived experience of older migrants with MCI.

Cultural competence

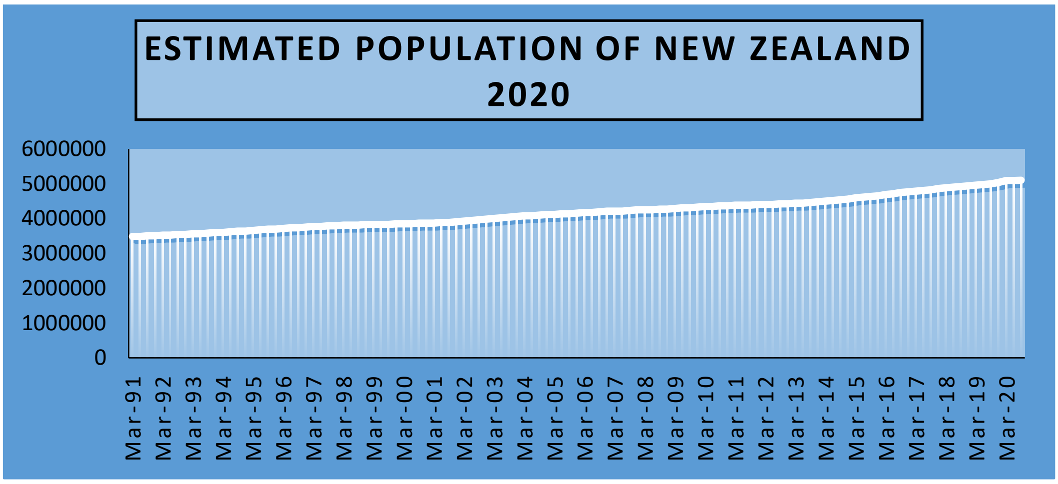
As a mental health professional, it is vital to deliver culturally competent care and support to individuals and their families/whānau. Cultural competence is primarily about health professionals' self-awareness, attitudes, skills, and knowledge, which is essential to working effectively and respectfully with people from diverse cultural backgrounds (New Zealand Medical Council, 2019; Nursing Council of New Zealand, 2020). There is a gap in research on MCI in the Aotearoa New Zealand health system and the experiences of the older migrant population. From a cultural perceive, there is a need to understand the reasons that shape their cognition and understand stigma and behavioural responses to culture (Beller et al., 2017; Dean et al., 2014). It is essential to recognize the complexity of MCI combined with knowledge of different cultures to improve health outcomes. A one-size-fits-all approach does not work with all older migrants because they are not homogeneous. Therefore, exploring broader ways of capturing the cultural understanding of older migrants with cognitive problems is imperative. For instance, phenomenological approaches are one exciting way for people to share their lived experiences on MCI, as discussed further in the methodology section (Neubauer et al., 2019).

The demographic of Aotearoa New Zealand

Aotearoa New Zealand is undergoing an unprecedentedly rapid demographic shift, and the most obvious example of this change is due to net immigration and increased longevity (Stats NZ, 2022). Aotearoa New Zealand has a multicultural population (Figure 1; Statistics New Zealand [Stats NZ], 2018). Figure one below provides an estimated population of New Zeeland. The graph shows how the population has grown significantly by 12,700, or 0.2 per cent, over the year. This trend is likely to have reached 5.12 million on 30 June 2020 (Stats NZ, 2022). The 2018 census indicates that much of the population is of European descent (70%). Indigenous Māori is 16.5%, followed by Asian (15.3%) and Pacific Islander (9.0%). Auckland is by far the most ethnically diverse region in New Zealand, with over 43% identifying as European; 28.5% Asian; 11% as Māori; 15.5% Pacific Islander; and 2% from Middle Eastern, Latin American, and African countries (Stats NZ, 2020).

Figure 1

PICO model of literature search



Adapted from Stats NZ (2020). Copyright in the public domain

Most New Zealanders live in an urban environment on the two main islands, the North and the South. Auckland is the biggest city; the capital Wellington is the second-largest city. Christchurch, Dunedin, Hamilton, Tauranga, and Napier-Hastings are also large cities. Auckland has over 1.6 million people, which is 34% of the total population (Stats NZ, 2020). This number is rapidly increasing because of net immigration. Christchurch and Dunedin are the other two major cities in the South Island. This study has focused on the demographic of older migrants living in Auckland instead of focusing on the whole country.

Demography of older people

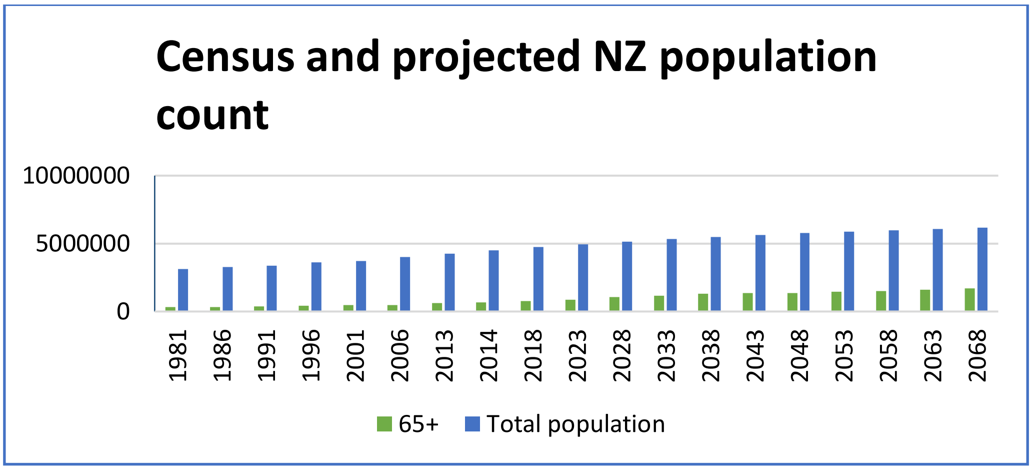
The UN figures show that people aged 80 and over will likely triple from 143 million in 2019 to 426 million by 2050 (WHO, 2020a). In general, an older person is defined as over 60 years, yet there is no clear consensus on when old age begins. Being old or a senior citizen also depends on gender, culture, physical health, reliance on others for healthcare and psychological circumstances (WHO, 2020). Some evidence suggests that socio-economic and cultural values and beliefs too play an essential role in ageing (Löckenhoff et al., 2009). Various other adaptations and interpretations of old age depend on pension laws; understanding cohabitation and social relations are also linked to later life (Hupkens et al., 2018). In fact, 60-year-olds may be in sound physical condition, but their psychological health, skills, and performance levels may be affected (WHO, 2017). Most developed countries have adopted the chronological age of 65 as a starting point in the definition of an older person (WHO, 2020a). Recognizing an ageing population worldwide has implications for the economy and managing health services is imperative.

In other countries, such as China, old age starts at around 50; in France, it begins at about 70, although the retirement age is 62 (Eldernet, 2020). Suffice it to say, the concept of what it means to be an older adult is not consistent worldwide since the ageing process differs across countries and cultures (Löckenhoff et al., 2009). Hence, society often uses other benchmarks to determine old age, such as family status, physical appearance, or age-related health conditions (UN, 2019; WHO, 2021).

In Aotearoa New Zealand, life expectancy is higher than in other developing countries, and the typical retirement age is 65 years. The population aged 65 years and older has doubled since the 1980s and is forecast to rise further by 2068, the most substantial growth between 2011 and 2036, as the 'baby boomers' (born between 1946 and 1965) reach the 65+ age group. An estimated 21 to 24% of New Zealanders will be aged 65 and over in 2068 (Stats NZ, 2020). Figure 2 shows the Aotearoa New Zealand population at the last census, estimated to exceed six million by 2068 (Stats NZ (2020).

Figure 2

Quick statistics of people aged 65 and over



It was adapted from Stats NZ (2020) under the Creative Commons Attribution 4.0 International license 2021.

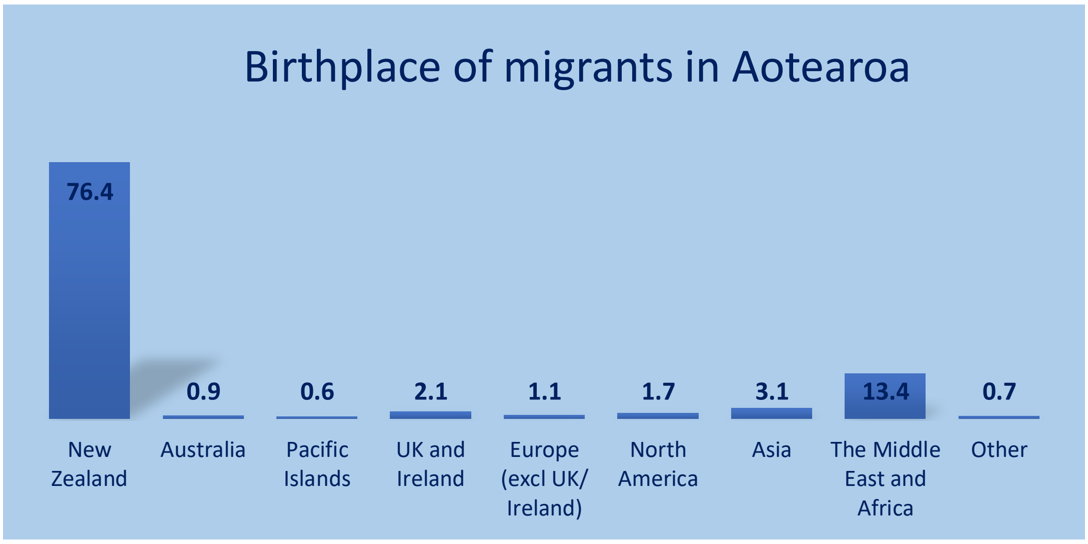
Demography of older migrants

An older migrant is someone who emigrates when they move to a foreign country as a younger person and then reaches 60 years and over (United Nations Economic Commission for Europe [UNECE], 2016). This move can be temporary or permanent from countries distinct from their birth country (International Organisation for Migration, 2021). In this study, older migrants were from various cultural and ethnic backgrounds (Stats NZ, 2020). Older migrants have known vulnerabilities that vary depending on different ethnic groups and are affected by age, gender, and socio-economic status (Kristiansen et al., 2016; UNECE, 2016).

It is difficult to estimate the precise number of older migrants living in Aotearoa New Zealand, because some migrants later gained citizenship and consider themselves New Zealanders rather than a migrant. Migrants have diverse origins and live in different parts of the country, but most live in Auckland City. Figure 3 below offers an estimated overview of the migrants in Aotearoa New Zealand. Zero to 90 signifies the percentage of the population. Older migrants are of diverse ancestry and are mainly from Europe, Asia, the Pacific Islands, the Middle East, Latin America, Africa, and several other countries (Stats NZ, 2018; Fig 3).

Figure 3

Birthplace of different ethnic groups, 2018 Census



Data extrapolated from Stats NZ (2018). Copyright in the public domain.

Aotearoa New Zealand is one of the most culturally diverse nations globally (Montayre et al., 2017). Older migrants comprise over 200 ethnic groups, and the latest estimate is that the ageing migrant population will increase to over 353,600 by 2033; and 1,258,500 million by 2037 in New Zealand (Auckland Council, 2021; MSD, 2020). Besides diversity, health disparities may also be an issue for older migrants because of their comorbidities, age, religious belief, and sociocultural views about health (MOH, 2017). Kanengoni et al. (2018) correctly pointed out that vulnerable older migrants need more health interventions and often have poor access to healthcare. Thus, an ageing migrant population poses challenges for the New Zealand Government. Improving services for older migrants with MCI is a necessity to tackle equity and fairness.

Government strategies

There is no specific policy for older migrants in Aotearoa New Zealand; the strategies discussed in this section focus on older persons, which apply equally to older migrants. Though several approaches inform the debate on improving the psychological well-being of older people, they are directly or indirectly linked to older migrants with MCI.

Healthy Ageing Strategy

The WHO (2015) document, *Political Declaration, and the Madrid International Plan of Action on Active ageing: A policy framework*, has influenced attitudes and policy about ageing. Since its inception, another recent strategy has replaced that plan, the *Global strategy and action plan on ageing and health 2016-2030* (WHO, 2020b) has outlined other positive strategy to establish and support the functional capability that promotes older persons to age well. In Aotearoa New Zealand, the *Healthy Ageing Strategy* has emerged from the WHO framework for developing the available capacity of older persons to improve their health and well-being (WHO, 2017). Over the next decade, this policy sets a strategic direction in providing services to New Zealanders in their later years to live well, age well, and have a respectful end of life in age-friendly communities (MOH, 2017).

The current New Zealand *Healthy Ageing Strategy* has superseded previous strategies, such as the *2002's Health of Older People Strategy* and strengthened the *Health of Older People Strategy* to align it with the latest (MOH, 2017;2016a; 2001). Both strategies were designed to provide person-centred approaches to addressing the social health determinants and giving weight to the end-of-life phase (MOH, 2016a) by reducing gaps and shortcomings in policies to improve older people's physical/psychological health and social well-being (MOH, 2016b). Despite promoting health and quality of life for all seniors, those with cognitive problems such as MCI are not fully addressed (MOH, 2016b, Yates et al., 2020).

Although the quality of life for all seniors has improved significantly over the past few decades, the well-being of older migrants still has some functional constraints (MSD, 2016). The *Healthy Ageing Strategy* is an essential plan for the health and well-being of older migrants, but for many, their health needs are not adequately met (Kanengoni et al., 2018; MOH, 2016b). Moreover, the literature has illuminated the lack of involvement of older migrants in healthcare and the many challenges they face (Neville et al., 2018). Previous studies have shown that many factors are involved in identifying health risks and resilience, drawing upon similar heterogeneous perceptions of ageing well in diverse ethnic older migrant groups, including both the positive and negative aspects (Conkova & Lindenberg, 2020; Par-Brownlie et al., 2020). Healthy ageing can be created through continued personal growth, receiving better support, and developing a sense of belonging, self-acceptance, and resilience, linking with family ties and fulfilling culturally integrated responsibilities and expectations. Some older migrants experience ageing negatively in the form of declining physical and cognitive health, problematic financial issues, language barriers and difficulties in addressing care needs (Davidsen, 2013; Nieboer et al., 2021; Ramsey et al., 2017).

Seminal contributions were made in the latest strategy, *Better Later Life – He Oranga Kaumātua 2019 to 2034*, which the New Zealand Government presented to provide older people with a better quality of life (MSD, 2019). It aims for older people to have the opportunity to have enough income and choose where to live, feel socially connected in their community and access affordable healthcare. The strategy supports older people in achieving financial security. It promotes healthy ageing, improving access to services, creating diverse housing choices and options, enhancing opportunities for participation and social connections, and making environments accessible for senior citizens. According to the Office for Seniors, this strategy highlights the importance of community for senior citizens suggesting that "ageing in the community safely and independently can improve older people's physical and mental health and wellbeing, and social connectedness" (MSD, 2019, p. 32). The question is, how does this strategy ensure that older migrants get good physical and mental health and stay connected to live happier lives (Office for Seniors, 2019)?

Better cognitive health

Government strategies regarding functional and psychosocial well-being interventions can enhance cognitive health for older people (Gates et al., 2014), which applies to migrants with MCI (Chen et al., 2020). The Government established the appointment of a Minister for Seniors in 1990, whose role was crucial in developing a strategic plan to promote, support and raise awareness for seniors, which is particularly important for those with MCI (MSD, 2020). A *Healthy Ageing Strategy* also supports better cognitive health for people with complex and diverse mental health needs, contributing to an environment that promotes self-worth and value for mental well-being (MOH, 2016a).

It is documented that older migrants have problems adapting to an unfamiliar environment, experience stress, have poor mental health, and do not fully engage in health services (Ladin & Reinhold, 2013; UNECE, 2016). Many questions remain unanswered as to why this occurs in practice. The healthcare needs of older migrants are complex, and the New Zealand Government has demonstrated its commitment to improving seniors’ mental health and well-being (MOH, 2016a). The *Healthy Ageing Strategy* does not fully address this issue for older migrants with MCI. More approaches are needed that focus on older migrants with MCI.

Dementia care strategy

Dementia is an irreversible, progressive, and debilitating disorder; people with this condition slowly worsen, with reduced ability to function well in daily life (NIA, 2019). However, for those with MCI, their memory problems can often be readily reversed with appropriate care and treatment (Fessel, 2019); if not, their cognition could deteriorate more quickly (Moreira et al., 2019). Early intervention is helpful and critical in helping understand the aetiological factors and the management of MCI (Alzheimer’s New Zealand, 2017). Therefore, a strategy is needed to help people with MCI access health care sooner than later.

The *New Zealand dementia care framework* (NZDCF) was one of the first strategies the New Zealand Government initiated to encourage health and social services to work together to help people with cognitive problems (MOH, 2013). It aimed to provide care and support for people with early stages of cognitive decline to the last stage of dementia (MOH, 2013). Emphasis is given to early assessment and treatment, promoting cultural competence, and providing lifestyle choices. The NZDCF guides local services to develop better support for older people in maximizing their independence and improving their cognitive health. Policy direction supports those with memory problems from early diagnosis to the end-of-life stage of dementia; it encourages stakeholders to work together to develop primary and secondary care pathways (MOH, 2013). One of these strategies is to maintain its relevance to older migrants with MCI who may have different aspirations and needs as they age and have health problems, disabilities, financial stresses, and access to health services (MoSD, 2021).

Although MCI is not explicitly mentioned in government strategies, references are made to cognitive problems – which are broad – MCI is also identified as a transition period between ageing and AD (Petersen et al., 2014) and so comes under a similar category to those with cognitive problems. As a result, more practice guidelines are needed to help health professionals quickly accommodate people with MCI and ensure equitable access to care and services earlier.

NZDCF was the starting point in government strategies to help identify those with early cognitive problems. Since then, there has been an increased need to address the shortcomings of people with MCI (Yates et al., 2020). To bridge this gap, Alzheimer New Zealand and the New Zealand Dementia Cooperative have developed another dementia plan: *Improving dementia services in New Zealand - Dementia Action Plan 2020 to 2025* (Alzheimer's New Zealand, 2020; Dementia Auckland, 2020). This plan aims to improve the treatment of preventable mental health issues, including MCI. Whānau, families and caregivers of people with cognitive problems should receive the support they need to support a life of autonomy, meaning and dignity (Dementia Auckland, 2020).

New Zealand's *Dementia Action Plan* helps connect older migrants to health and social services provided by the local Government and District Health Boards (DHBs) to enhance their cognitive health (Dementia Auckland, 2020). The mental health and well-being of older migrants are essential to improving their lives and making them more resilient (MOH, 2017). Recently, another report, *Dementia Prevention, Intervention, and Care: 2020*, has proposed the need to strengthen the Government's strategies to effect changes to support older people with MCI in the future (Livingston et al., 2020). The report reaffirms that people with MCI have the same rights, privileges, and obligations as those with dementia. Diagnosing MCI promptly allows seniors to make decisions early on about their future care planning and promptly identify where to access support. These strategies enable early interventions to help maintain the quality and quantity of life. For their family/careers, early detection of MCI gives them more time to adapt to the changes in their role, from family members to caregiving roles.

Defining Mild Cognitive Impairment

MCI is a transition phase between healthy ageing and dementia and is usually characterized by minor cognitive deficits affecting everyday life (Li et al., 2018; Petersen, 2004). The International Classification of Diseases (ICD-11) defines MCI with memory loss as the predominant symptom, often considered a prodromal stage of AD, and impairments are likely in other areas such as language and visuospatial executive functions (ICD, 2020; Petersen et al., 2018). MCI can be self-assessed when someone recognises, they have a cognitive problem in daily activities. However, MCI diagnosis can be missed. Hence in practice, cognitive issues are objectively assessed by health professionals. The approach is to take a subjective and objective history of cognitive changes and perform neuropsychological tests highlighting problems affecting at least one of the brain's four lobes (Canevelli et al., 2020). Individuals will be diagnosed with MCI when they have “memory impairment beyond that expected for age and education, yet are not demented” (Petersen, 2016, p. 404). However, the root cause of MCI may be physical and neurological problems, trauma, chronic substance abuse, or other aetiologies (WHO, 2020b).

From a psychiatric point of view, MCI was added to the mild neurocognitive disorder category in the last release of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and formally clustered under DSM-4, “dementia, delirium, amnestic or other cognitive disorders” (American Psychiatric Association, 2020). DSM-5 further describes MCI as a marked decrease in cognitive function, beyond regular changes observed in ageing, but not progressing to AD. However, the definition of MCI may be too restrictive because it does not capture all types of cognitive problems that may arise. Instead, the International Psychogeriatric Association and the WHO proposed the term “age-associated cognitive decline” to describe people with “a broader range of cognitive deficits” (Lopez, 2013, p. 412). Based on Petersen et al.’s (2004) view, MCI is often, but not always, a transitional phase from cognitive changes in normal ageing to those typically found in dementia. Symptoms of MCI can suggest loss of cognitive function, thinking, remembering, learning, reasoning, or behavioural abilities that impede a person’s quality of life and activities (NIA, 2020). Based on the definition of DSM-5, the preferred terms “forgetfulness” and “memory problems” are interchangeably used in this thesis to describe people with MCI.

What is known about MCI?

MCI is recognized worldwide as a severe cognitive health problem and an obscure area between intact cognition and dementia (Petersen et al., 2014). The classification of MCI has changed since the DSM-5's guide to diagnosing mental disorders (American Psychiatric Association, 2020). However, the core criteria for determining MCI have changed little over time (Petersen et al., 2014). Previously, the phrase “benign senescent forgetfulness” (Kral, 1962, p. 257) was used to describe the population of older people with mild but stable memory problems. Later, Reisberg et al. (1988) used the term MCI to describe early cognitive decline, as examined through cerebral medical imaging. Over time, an extensive literature has developed the concept of MCI by subscribing to a middle clinical phase between cognitive ageing and the first attribute of AD changes (Petersen et al., 2001, 2009). Petersen et al. (2014, p. 214) recategorized the category of MCI as causing minimal impairment of “instrumental activities of daily living” and can also be “secondary to other disease processes”, such as neurodegenerative or mental disorders

In clinical practice, MCI has been thoroughly investigated from many perspectives: clinical testing, medical imaging, obtaining a genetic history, and the search for pathological and epidemiological data (Callow & Alpass, 2014; Petersen et al., 2018; Shepherd & Nayak, 2019; Reisberg et al., 1988). The Clinical Global Impressions (CGI) Scale for the mental health professional have been developed to classify one or more cognitive measures more rigorously and with specific criteria for MCI (Busner & Targum, 2007; Petersen et al., 2014). In the past few decades, the rating of MCI has been strengthened to include the clinical onset of memory problems in individuals who do not meet all AD diagnosis criteria (Petersen et al., 2018). Further explanation of the assessment and treatment of MCI is contained in Chapter Two.

Types of MCI

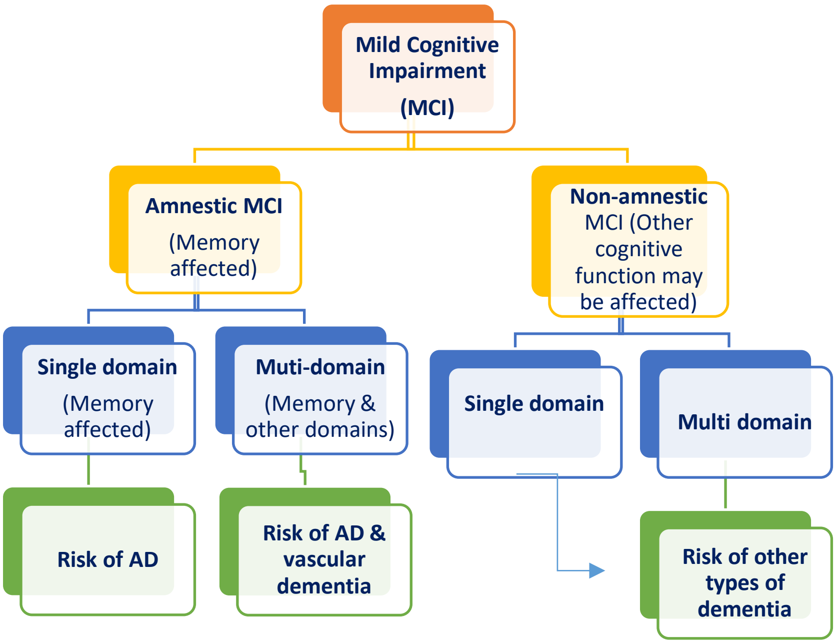
Epidemiological literature on the types or subtypes of MCI shows a significant variation over time. MCI can be divided into two kinds: amnestic MCI, which mainly affects memory, and non-amnestic MCI, which affects non-memory thinking skills. This includes making sound decisions, judging the time or sequence of steps needed to complete a complex task, or visual perception (Banner Alzheimer's Institute, 2016; Hemmy et al., 2020). Diagnosis of MCI is usually conducted with cognitive testing tools described in more detail in Chapter Two, gathering a history of cognitive problems and carrying out diagnostic medical imaging (Dementia Australia, 2020). Amnestic or non-amnestic can be further divided into several areas, depending on the number of different regions affected in the brain, showing problems with either or both learning and memory skills (Banner Alzheimer's Institute, 2016).

There is considerable literature on the criteria for distinguishing MCI. In practice, a health professional usually performs such a task by diagnosing subtypes of MCI based on a distinction between executive function, memory, language, or visuospatial to normal functional activities (Hemmy et al., 2020). Understanding MCI types and subtypes help determine therapeutic and tailored interventions for specific precursor forms of cognitive problems (Petersen, 2014), as this is a severe disease, but MCI is reversible, and the symptoms can improve or worsen (Alzheimer's Association, 2020).

Figure 4 below further clarifies distinct types of MCI. Someone with MCI can more accurately be categorized as amnestic or non-amnestic MCI. In the amnestic type, memory loss is more predominant and associated with a high risk of further conversion to AD, whereas individuals with non-amnestic impairments in other memory domains have a higher risk of converting to other forms of dementia (Csukly et al., 2016).

Figure 4

Types of MCI



The figure put together by Ray Jauny to explain multiple domains of MCI

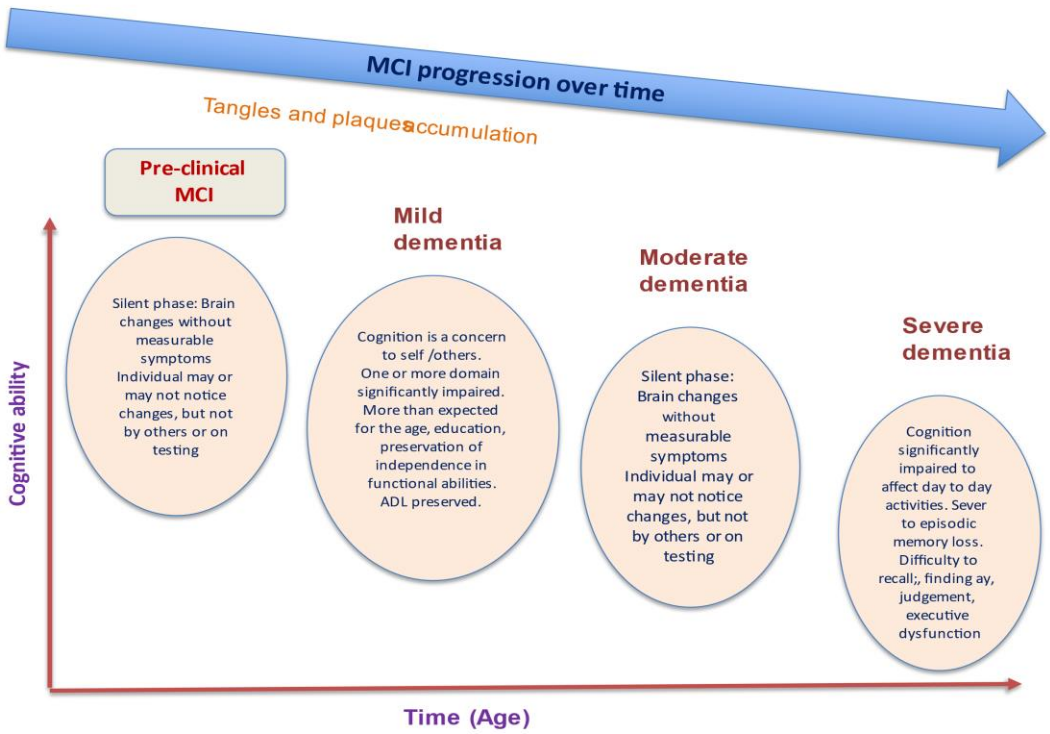
Progression

It has been suggested that the probability of progression from MCI to any form of dementia is three to five times higher than those with normal cognition (Campbell et al., 2013). MCI can become a serious health problem; about 15% of people with MCI progress to the early stages of dementia (Jia et al., 2020; Michaud et al., 2017). Risk factors of MCI comprise physical, psychological, and sociocultural factors playing a decisive role in the life of a vulnerable older person (Liu et al., 2020). In addition, advanced age, a family history of mental health problems and other medical complications can contribute to the progression of MCI (Alzheimer's Association, 2020; Kremen et al., 2014). As far as migrants are concerned, various sociocultural factors contribute to their progressive ageing and MCI (Canevelli et al., 2020). It is essential to help reduce the risk of progression of MCI to any form of dementia in older people. Although the literature seems consistent, MCI has a greater risk of dementia progression (Figures 5 and 6), but this condition often returns to normal status or has no progression to dementia (Petersen & Yaffe, 2020).

Figure 5 below explains the journey of someone diagnosed with MCI and its likely conversion to dementia. Four phases describe cognitive ability before they have MCI and how over time, cognition worsens, and many end up experiencing severe dementia:

Figure 5: *Journey of MCI to dementia*

Figure designed by Ray Jauny

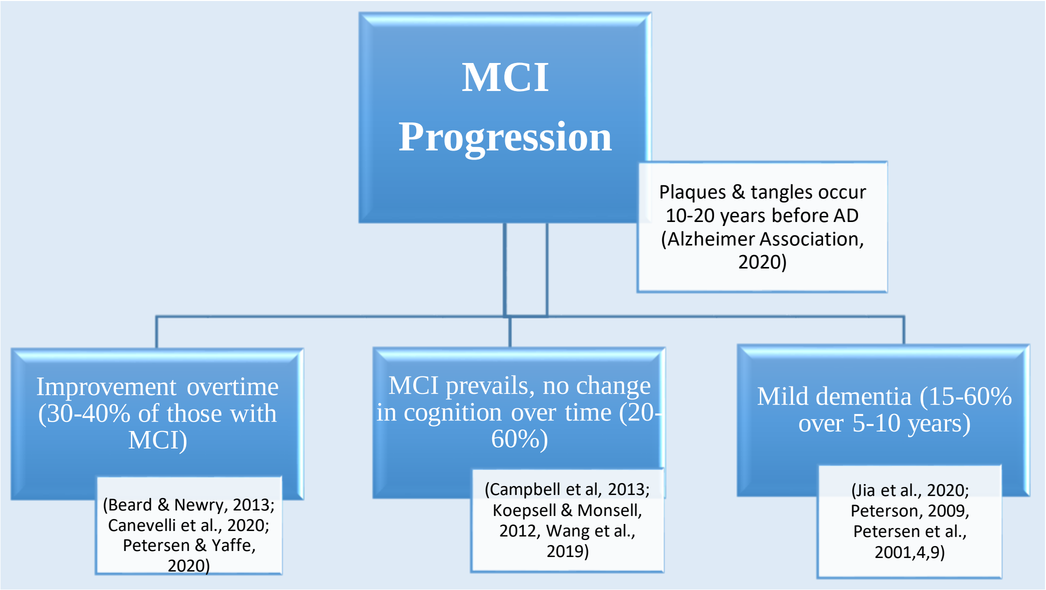


Despite the progression of MCI, it is imperative to acknowledge prevention strategies that can improve health outcomes and reverse this condition (Bredesen et al., 2018; Koepsell & Monsell, 2012). It is also equally important to recognize that most people with MCI are not affected similarly. Many people can live and work independently because the symptoms are not as severe as dementia. Prior research suggests a four-year conversion rate of 24.4% for those with cognitive problems developing MCI, with 10.9% getting dementia afterwards (Lu et al., 2021; Mitchell et al., 2014). Other research suggests that between 2 and 31% of those diagnosed with MCI might return to stable cognitive function over time (Beard & Newry, 2013; Canevelli et al., 2020; Petersen & Yaffe, 2020). In contrast, other authors have found that 20–60% of people with MCI remain stable for years without progressing to dementia (Campbell et al., 2013; Koepsell & Monsell, 2012; Wang et al., 2019). Unfortunately, about 15 to 60% of the symptoms of MCI will worsen over time, resulting in AD within 5 to 10 years (Jia et al., 2020; Petersen et al., 2009, 2004).

Figure 6 below explains the progression from MCI to dementia. Progression varies from person to person and depends on several factors, including the accumulation of plaque and tangles and physical and psychological health (Weir, 2019). It is important to note that everyone with MCI has a unique story, but someone diagnosed with MCI can progress to AD faster than one without.

Figure 6: MCI Progression

The progression of MCI was designed by Ray Jauny to show the percentage of improvement or change in cognition over time.



Prevalence

There is no epidemiological study of the prevalence of MCI in the older migrant population in Aotearoa New Zealand, despite significantly affecting their health and well-being (Callow & Alpass, 2014; Yates et al., 2020). The incidence rate is underestimated and undetermined (Callow & Alpass, 2014). As the rate of dementia is estimated to be 9% in people aged 65 years and over and 30% in those aged 85 years and over (Neurological Foundation, 2020), it would be logical to assume that the older population with MCI is much higher.

Older migrants often face multiple jeopardy and discrimination (Harnois, 2015). They are disadvantaged because of their chronological age, lower educational status, underemployment, and suffer from psychological ill health (Davies et al., 2010; Xu et al., 2017). Many are prone to physical health problems and psycho-social problems, as are other seniors. As migrants age, it is not uncommon for them to suffer from deteriorating cognitive issues such as MCI (Xu et al., 2017). There are growing concerns about the link between older migrants, MCI, loneliness, and psychological trauma (Bray et al., 2018; Kirmayer et al., 2011; Wright-St Clair et al., 2017). Acculturation to a new country may further exacerbate the incidence of MCI, specifically among older migrants (Gruebner et al., 2017).

Research aim

This research asks the question:

What is the lived experience of older migrants with mild cognitive impairment?

This study aims to capture the lived experiences of older migrants, and lessons learned can highlight various ethnic and cultural factors that affect cognition. Phenomenological studies are a unique approach to assisting health researchers in learning from individual experiences (Neubauer et al., 2019). This is an added strength of this study because the findings highlight the importance of the vulnerabilities of older migrants with MCI and understanding the complexity of diverse cultures. Knowledge about MCI can inform policy makers in Health New Zealand, the local government, and other stakeholders working with older migrants in Aotearoa New Zealand. Lessons learned may enable older migrants to live well, stay well, and get well, as stated in New Zealand's *Healthy Ageing Strategy* (MOH, 2016a).

Structure of this thesis

Chapter One: Setting the stage

Chapter one sets the stage by describing the background of this study, including what brought me to do this research question. The demographics of the Aotearoa New Zealand population with MCI are summarised to provide the extent of migrants experiencing MCI. Furthermore, relevant government strategies and frameworks that seek to support and improve the psychological well-being of older migrants with MCI are detailed. What is known about MCI, how this condition progresses, and its prevalence has also been detailed.

Chapter Two: Literature review

This chapter outlines the review of the literature on MCI. It explores the background information on older people and older migrants. It underlines the classification, epidemiology, assessment, treatment, and health outcomes of older migrants with MCI. There is an overview of the literature on physical, psychological, social, and cultural issues faced by older migrants with MCI.

Chapter Three: Research design

The research design outlines this study's methodology, method, and philosophical basis. It explores the research question and how Heidegger's philosophy is a valuable and rigorous way to understand human experience deeply. This chapter summarizes how hermeneutic philosophy informs and guides this study and offers other philosophers' contributions. The research process reveals the data collection, data analysis and ethical principles.

Chapter Four: Being thrown into distressing events

The first findings chapter examines how older migrants are thrown into distressing events. Their stories show family trauma, retirement, acculturation, health complications and social isolation that have affected their memory.

Chapter Five: Being connected with others

The subsequent findings highlight how participants connect with other seniors. It reveals stories of older migrants socializing, praying, and interacting with family, friends, and people of diverse cultural groups.

Chapter Six: Forgetting every day

Forgetting every day highlights the experience of participants forgetting the daily events or activities of their lives. The stories of older migrants reveal their difficulties in remembering daily tasks and notable events and subsequent feelings of embarrassment or frustration. Distinct cultural meanings about forgetfulness are also exposed.

Chapter Seven: Knowing how to make sense of MCI

The last findings chapter explores the experience of older migrants in making sense of memory problems and describes their self-management strategies. The participants emphasize their concerns and daily struggles with their memory. Common approaches to stimulate the brain are revealed.

Chapter Eight: Discussion

The last chapter describes the phenomenological importance of the findings and their implications for practice, education, and research. The strengths and limitations are explained, and a final summary of the findings is presented. The chapter also captures my reflection on this doctoral journey and highlights suggestions for further research.

Summary

This chapter outlined the basis and justification for this research on MCI and its relationship with older migrants. I explained the journey that led me to choose the research subject and its rationale. I revealed the relevance of this research regarding my personal, professional, and academic stance. The demographic of Aotearoa New Zealand, and relevant strategies in connection with MCI were outlined, demonstrating the importance of bringing in new knowledge. Types and subtypes of MCI, and its progression, were described. The prevalence of memory problems in older people is explored, focusing specifically on older migrant populations. The next chapter details the relevant literature and empirical information about MCI.

Chapter Two: Literature Review

Introduction

In order to explore MCI and its relevance to older migrants, it is indispensable to review the literature to outline what is known about this topic. My professional experience working with people who have MCI has informed my vision and ability to understand them. While no specific studies have been conducted on MCI in Aotearoa New Zealand, I have considered the relevant global literature on MCI and its significance to older migrants globally. The New Zealand Government's strategies for healthy ageing and dementia care pathways are considered significant milestones in addressing the needs of people with cognitive problems (Dementia Auckland, 2020; MOH, 2013, 2016). Various published literature, guidelines and strategies on MCI are explored, showing how MCI affects older migrants' health and well-being.

MCI literature and its importance to older migrants were sought from all available online resources. I narrowed the literature search to scholarly databases for more specific information on identified data relating to MCI. The review presents several themes: prevalence, epidemiology, aetiology, risk and socio-cultural factors affecting people with MCI. A review of specific cognitive impairment assessment tools and treatment options that also apply to MCI in clinical settings is described. The impact of social isolation and acculturation is explored and highlights how older peoples' memory is affected when they migrate to an unfamiliar country. Finally, I explore the literature on the progression of MCI and how its impact is experienced in the ageing migrant population.

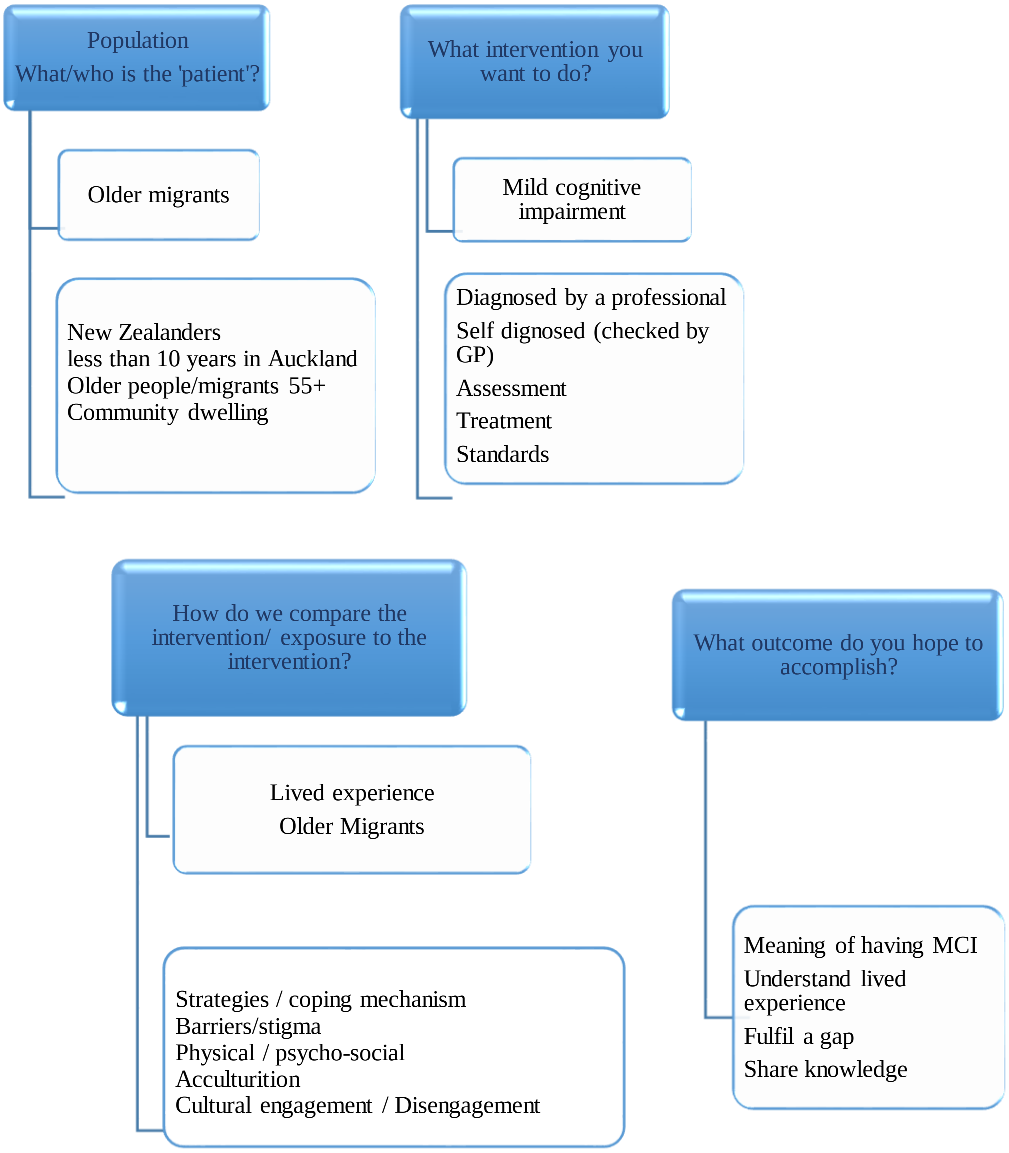
This research topic is unique in Aotearoa New Zealand, as there is a lack of research focusing on the phenomenological experience of older migrants with MCI. Although the current literature review has general information about seniors with MCI, there is a gap in research into older migrants with MCI using phenomenology as a methodology.

Search strategy

The research is focused on older migrants' lived experiences of MCI. First, my strategy was to identify as many sources as possible and look for literature over the past two decades, including books, peer-reviewed online journal articles and websites. I then used the Populations/People/Patient/Problem, Intervention (s), Comparison, Outcome (PICO) model (Figure 7 below) to generate basic questions as outlined in the literature review process (Eriksen & Frandsen, 2018). The PICO model helps to provide a structure to the purpose of the research, as well as identify synonyms and alternative meanings used in the framework:

Figure 7: PICO Model

PICO model of literature search adapted from Eriksen & Frandsen's (2018) model.



The PICO model helped to identify and outline the primary sources of literature. The keywords used to elicit relevant literature were: [Older migrant OR ageing (aging) migrant AND immigrant]; AND [older people OR older person]; AND [cognition OR memory impairment], AND mild cognitive impairment; AND [living experience OR lived experience].

The databases searched articles from Psych INFO, CINAHL, and Cochrane Library, in English only and published between January 2010 and September 2022 to include the latest literature worldwide. Published papers, dissertations, theses, and research projects from the Auckland University of Technology (AUT) Tuwhera databases were accessed and included. Physical searches at AUT Library were conducted to complement data on this topic.

As already stated, there is a lack of research on older migrants with MCI, especially those using a phenomenological approach. Hence, more search filters were added, incorporating terms such as lived experience AND relevant to [MCI] OR [mild dementia] OR [dementia] OR [Alzheimer’s disease], AND [ageing] OR [ageing], OR [phenomenology] and adding older people OR/AND [older migrants]. Research published over a decade ago relevant to MCI was considered a need for legacy references. I uncovered over 3,500 research articles on MCI and more on senior citizens but no specific research on older migrants. Then I narrowed the scope to include thorough research from peer-reviewed journals, English Language Studies, and studies focused on lived experience. After adding these criteria, over 200 research articles were relevant and formed part of this review.

Findings of the literature review

Each article was reviewed to ensure it was relevant to the research topic. I have read the papers a few times, taking notes and highlighting the appropriate words important for research. The primary literature was gathered, identifying fundamental notions and exploring some of the following questions:

- What are the main clinical features of MCI?
- What is the experience of seniors with MCI?
- What is the link between migration and experiencing memory problems?
- What are the socio-cultural connections of those with cognitive issues?
- How do older people with MCI manage this condition?

The literature review identified published phenomenological studies, but there were patchy findings on older migrants' experience with MCI. There was much research on dementia and the ageing population with broad themes relevant to older migrants. In this section, initially, I will present data on the prevalence of MCI, its impact, progression and related risk factors. Next, the assessment and treatment are uncovered. The experience of older migrants with MCI is explored, and how it affects the lives of seniors, including difficulties in accessing health services. A considerable body of literature on social isolation/ loneliness, psychological well-being, acculturation stress, and socio-economic and cultural factors influence older people and their connection with MCI. Cultural factors are intertwined with spiritual and religious beliefs affecting the perception of memory problems. Finally, I convey the stigma associated with MCI and how it can have far-reaching and lasting consequences on individuals and their families. A better understanding of these topics means understanding the lived experience of older migrants, which justifies the phenomenological approach taken in this study (Bray et al., 2018). The next sections highlight these findings in depth.

Prevalence

The prevalence of MCI among older people is increasing globally and in Aotearoa New Zealand (Parlevliet et al., 2016). Several cross-sectional studies suggest that older people have an increased risk of MCI and dementia (Jia et al., 2020; Wang et al., 2019; Mavrodaris et al., 2013). Concerning older migrants, one study shows that MCI is expected to increase proportionally in ageing populations worldwide regardless of migration status (Mavrodaris et al., 2013). In a US demographic survey, the estimated prevalence of MCI varied from 3% of subjects aged over 60 to 15% for people aged 75+ years (Wang et al., 2019). In comparison, a

Swedish study found that overall MCI was 22.6% (95% confidence interval) of 1,000 participants aged 60 years and over (Overton et al., 2019). These fluctuations have different aetiology and risk factors (Hussin et al., 2019). Moreover, Parlevliet et al.'s study (2016) found MCI and dementia to be three to four times more prevalent in most non-Western migrant groups than in the native Dutch population. Hence, understanding such prevalence is essential for planning and improving healthcare services for not just older migrants but all senior citizens.

In Aotearoa, New Zealand, Callow and Alpass' (2014) study estimated an MCI rate of 2.4% in individuals under 55 years old. Two per cent occurred in those between 55 and 64 years old, 4.4% in those between 65 and 74 years old, and 10.5% in those over 75 years. This study estimated that over 3% of the ageing population might have MCI, but there is no data identifying how many are migrants. There is no definitive study on the prevalence of MCI among older migrants, although several studies focus on dementia, including MCI (Rivera-Rodriguez et al., 2021; Yates et al., 2020).

Risk factors

MCI is a real problem affecting the ageing population worldwide due to its high risk of progressing to AD (Petersen et al., 2014). There are well-known risks associated with MCI, such as exposure to pathogens, age, genetics, lower educational performance, and other medical problems (Campbell et al., 2013; Xu et al., 2020). The risk factors of MCI are high among older migrants, which is likely to be even higher in the absence of broader studies (Jia et al., 2020). MCI can be influenced by other risk factors, although evidence of abnormal genetic brain changes has been found identical to those with AD (Alzheimer's Association, 2020; Campbell et al., 2013). Risk factors also indicate beta-amyloid plaques, neurofibrillary tangles, reduced blood flow to the brain, chronic inflammation and evidence of trans ischaemic attacks (TIAs)/strokes, ventricular shrinkage and drug interactions (Alzheimer's Australia, 2020; NIA, 2020).

Several contributory factors have been identified as exacerbating the risk of MCI. For example, chronic physical health problems are reported in up to one-third of cases that affect cognition over time (Mavrodaris et al., 2013; Parlevliet et al., 2016). Unfortunately, these problems are often linked to significant physical morbidity and death (Hussin et al., 2019). In addition, people diagnosed with other neurological or psychological issues are also more prone to developing MCI than the general population (Geda et al., 2008). Moreover, a meta-analysis reports that depression, emotional apathy, sleep disorders and psychotic disorders are other precipitating factors for MCI (Wang et al., 2019).

Social health factors may also contribute to cognitive problems among older migrant populations. Evidence points to a deterioration in health when older migrants retire and migrate to unfamiliar countries (Montayre et al., 2017). But the needs of older migrants are often overlooked because they are culturally and linguistically diverse. Unfortunately, many faces psychological problems during migration, which ultimately contributes to the development of MCI (Livingston et al., 2020). These psychological problems may result from acculturation, stress, mood disorders, and cognition factors (Gruebner et al., 2017). As far as we know, older migrants become more sedentary and adopt different social and dietary habits (Kopp, 2019). A changed lifestyle that includes smoking and not working may also aggravate chronic health problems and ultimately affect cognition (Buja et al., 2013; Taylor et al., 1992; Vallance et al., 2018; Xu et al., 2018).

On the other hand, epidemiological data show that people with an unhealthy lifestyle have more physical and psychological problems, such as MCI (Lam et al., 2015; Livingston et al., 2020). Despite research showing that good nutrition and physical activity protect against cognitive decline (Callow & Alpass, 2014; Vanoh et al., 2017). On the other hand, studies have shown that poor physical health and an inactive lifestyle can make some people vulnerable to developing MCI as part of the migration process (Parlevliet et al., 2016). A closer look at this issue in a Netherlands study points to diabetes, hypertension, and cardiovascular disease contributing to cognitive decline (Agyemang et al., 2014). Additionally, mixed-method research in the US shows that some ageing citizens have a significantly higher risk of memory problems such as MCI (Beard & Neary, 2013). A further study reported that being older and single was a significant risk factor among senior Chinese citizens, who were three times more likely to develop MCI (Xu et al., 2020). Another study in Malaysia reports that hyperlipidaemia, being less educated, reduced exercise, limited use of modern technologies, and inadequate diet and calorie restriction contributed to increased cognitive problems (Vanoh et al., 2017). A further question is whether issues such as lack of mental stimulation and the relationship between unhealthy lifestyles and mental inaction contribute to the worsening of memory (Hussin et al., 2019). Thus, there seems to be a consensus that a lack of mental or physical activity is a complex risk factor that, if controlled, can reduce the incidence of MCI (Jia et al., 2020). It is central to understand how to modify these factors to reduce the risk of cognitive problems in older populations.

Assessment

Early assessment and prompt intervention are crucial to managing MCI. Research shows that up to 45% of people who meet the criteria of cognitive problems either do not receive a formal diagnosis or receive it too late for clinical interventions to be helpful (Lafortune et al., 2013). Still, early assessment aids in ensuring people with cognitive problems quickly access support, information, and treatment (Alzheimer’s New Zealand, 2017). Early detection of MCI, even when subtle signs are reported, can offer clinical improvements or enhance cognitive health outcomes. Livingston et al.’s (2020) study reports that prompt assessment of risk factors can delay mental deterioration and improve quality of life.

Early MCI assessment is a significant challenge in clinical practice settings. For example, a UK-based survey estimated that only a third of the older population surveyed had a cognitive problem (National Audit Office, 2007). Another study in the US pointed to the refusal of participants to do routine memory tests to detect cognitive issues for fear of losing autonomy, fear of nullifying their driver’s license, difficulty getting health insurance, keeping an existing job and fear of the need for advanced care (Boustani et al., 2005). Due to such refusal, the actual number of people with MCI may be higher than current estimates due to an unwillingness to be assessed. These two studies highlight essential aspects when determining MCI in the older population.

Assessing a person with MCI can be complex because it can be affected by several socio-cultural factors (Cullen et al., 2007). Thus, understanding the cultural worldview of older migrants is essential because of attitudes towards cultural differences, knowledge of diverse ethnic practices, and skills (Ardila, 2005). In some cultures, when assessing cognitive problems, it is often construed as dementia; to others, it may not be recognized as a significant problem (Beller et al., 2017). Despite these problems, a lack of understanding of culture has been linked to poor psychological health in some ethnic groups (Bender & Beller, 2016). Nevertheless, it is essential to have a relevant assessment tool, as outlined in the following section.

Psychometric tools

To date, there are no specific assessment tools to diagnose MCI formally. However, some standard psychometric tools for assessing all cognitive problems may help diagnose MCI in older people. Psychometric tools assess balance, sensory response, reflexes and other neurological functions to help identify cognitive deficits (NIA, 2019). The following tools are widely used in clinical settings in Aotearoa New Zealand:

- MMSE (Mini-Mental State Examination) is a short cognitive assessment tool commonly used globally. MMSE evaluates various cognitive subsets, including attention, language, memory, orientation, and visuospatial skills (Folstein et al., 1975). Unfortunately, it is not widely used in mental health settings in Aotearoa New Zealand, because it is copyrighted and requires a license fee.
- Montreal Cognitive Assessment (MoCA) is another short and popular cognitive assessment tool for cognitive problems. Its availability in multiple languages helps health professionals assess MCI and dementia (Nasreddine et al., 2005). This tool also requires a license fee from the owner.
- Addenbrooke’s Cognitive Examination (ACE-R) is a free and popular comprehensive assessment tool for detecting cognitive dysfunction, comprising tests of attention, orientation, memory, language, visual perception, and visuospatial skills (Mioshi et al., 2006). It is now replaced with a newer version, the ACE-111, which was developed to remove the MMSE elements from the ACE-R, as the MMSE is no longer an open-access tool (Hsieh et al., 2015). ACE-111 remains the most popular assessment tool in clinical practice globally.

- Mini ACE is another free tool, a shorter version of ACE-111 and valuable in detecting cognitive impairment. It has been translated worldwide and is widely used in various clinical settings (Hsieh et al., 2015).
- The Rowland Universal Dementia Assessment Scale (RUDAS) is a free, short cognitive screening instrument. It is designed to minimize the effects of cultural bias and language diversity on assessing baseline cognitive performance (Basic et al., 2009). This tool is more suitable for those for whom English is not the first language.

Concerns about sample sizes, lack of replicability of studies, and inadequate evidence make it challenging to recommend tools for assessing MCI (Aslam et al., 2018). According to the NIA (2019), before diagnosing MCI, consideration of medical problems, family history of cognitive problems, symptom severity, behavioural and personality changes, and medication interactions are vital. Psychometric tools alone are not always sufficient to assess MCI, but they help diagnose someone with MCI. It is also common practice for a person and family to self-assess the symptoms of forgetfulness or short-term memory problems, which helps establish a baseline for health professionals.

Additional cognitive self-assessment tools are needed, considering the costs of the tools and their availability to all clinicians. Self-assessment tools through an application or internet-based resources can support identifying people with symptoms of MCI or other forms of cognitive impairment (Charalambous et al., 2020). When these assessment tools indicate cognitive problems, further tests or professional assessments are needed to confirm a diagnosis (Alzheimer’s Association, 2020).

Biomarkers

Neuropsychological tests and brain imaging options are often used to assess cognitive functioning, namely (a) computed tomography; (b) magnetic resonance imaging; and (c) positron emission tomography (Shepherd & Nayak, 2019). Biomarkers can determine how well the body responds to a disease or condition. A biomarker such as medical imaging are essential complementary signs to show links between symptoms of MCI and pathophysiological processes, thus underlying cognitive problems (Ng et al., 2018). Medical imaging and pathological history are one way to track MCI and, at the same time, reveal plaques and tangles, which usually build up years before signs of cognitive problems arise (Weir, 2019). Studies show that amyloid plaques, tau and neurofibrillary tangles are neuropathological features of AD, and they accumulate in the brain’s cortical regions many years before affecting the individual (Small et al., 2006; Weir, 2019). The accumulation of these biomarkers in cerebrospinal fluid is potentially clinically valuable for identifying the disease processes and contribution to MCI (Giau et al., 2019). Despite the importance of such biomarkers as significant risk factors leading to AD, not everyone with these biomarkers develops MCI (Henderson, 2019; Lee et al., 2019).

Neurological disorders

It is challenging to assess MCI in clinical practice because MCI sufferers may have other neurological problems, such as depression and anxiety (Petersen et al., 2014). MCI could be a treatable psychiatric condition affecting cognition (NIA, 2020). For example, a person with a mood disorder may have reduced understanding, which is construed as MCI (Giau et al., 2019; Geda et al., 2008). Similarly, those with a psychotic disorder may have reduced awareness and insight, which could be interpreted as MCI, and these changes can vary across individuals (Bowie & Harvey, 2006). Therefore, the assessment of MCI requires professional skills, knowledge and proper tools. It is also essential to rule out all medical problems before the cognitive issues are attributed to MCI (Yates et al., 2017). The following section explores available treatments for MCI.

Treatment

This section presents available medical and nonmedical approaches to treating cognitive impairment, the benefits, and disadvantages. Some of these treatments are used for treating MCI in clinical practice, although treating the root causes of memory problems is a priority (Doody et al., 2009; Lu et al., 2009; Xu et al., 2020). Nonetheless, there is currently no treatment to cure dementia worldwide, but some medications can improve memory and prevent the deterioration of cognitive function (Alzheimer’s Association, 2020).

Acetylcholinesterase inhibitors

Acetylcholinesterase inhibitors (also called Cholinesterase Inhibitors [CIs]) are chemicals whose main effect is to block the normal breakdown of acetylcholine, a neurotransmitter. Acetylcholine is part of the parasympathetic nervous system and is a primary neurotransmitter. The autonomous nervous system contracts smooth muscles, distend blood vessels, and slows the heart rate. CIs are designed to help with this process by improving memory and other brain functions by influencing acetylcholine degradation in the body and reducing the communication of nerve cells in the brain (Lu et al., 2009; Xu et al., 2020). The primary function of CIs is to catalyze and prevent the degradation of the neurotransmitter acetylcholine (Purves et al., 2001).

Anticholinesterase inhibitors have varying degrees of effectiveness in the treatment of cognitive impairment. A recent clinical study has shown that anticholinesterase inhibitors are associated with modest mental benefits and lower mortality risk, partly because of the reduced risk of myocardial infarction, stroke, and cognitive effects (Xu et al., 2020). Short-term benefits were observed to reduce cognitive decline, increase the ability to perform daily activities, and improve behaviour (Ndukwe & Nishtala, 2015). Acetylcholinesterase inhibitors work by increasing the concentration of acetylcholine in brain receptors, resulting in increased or improved neurological connections (Xu et al., 2020).

Currently, three main acetylcholinesterase inhibitors are approved for use in Aotearoa New Zealand: Donepezil, Rivastigmine and Galantamine (Pharmac, 2020). These CIs have long played a crucial role in most treatments for those with more advanced stages of cognitive impairment (Dou et al., 2018). In Aotearoa New Zealand, CIs has been available since 2010 in clinical practice. However, the consideration for using these medications was the cost and lack of consensus on their effectiveness (Alzheimer's New Zealand, 2008). Nevertheless, it has been available for decades in other parts of the world to thwart the progressive nature of cognitive degradation with varying degrees of success (Xu et al., 2020).

There are several CLs in practice, of which Donepezil (the brand name Aricept) is the main one. Donepezil has been subsidized and available over the past decade and is most commonly used as a CL for the symptomatic management of people with cognitive problems (Pharmac, 2020). In addition, Rivastigmine is another CL available in the form of oral tablets or transdermal patches (Exelon). It has been subsidized since 2014, and a generic version of the same medication has been fully funded since July 2020 (Pharmac, 2020). Galantamine is another CL available in Aotearoa New Zealand but is currently not subsidized. Galantamine has shown a significant decrease in the risk of severe dementia and managing behavioural and psychological symptoms of dementia among all three anticholinesterase inhibitors (Dou et al., 2018; Xu et al., 2020). Additionally, one study reports that treatment with such medications may delay the need for care in an aged-residential facility (Wattmo et al., 2018).

Cognitive enhancers are another group of medications that may also help prevent the degradation of neurons and improve cognition. In contrast, to the CLs, Memantine (a cognitive enhancer) is available on prescription in Aotearoa New Zealand but is not yet subsidized (Pharmac, 2020). It is the only glutamatergic drug (an important neurotransmitter) approved worldwide to enhance cognitive function (Ilhan et al., 2017). Memantine can also reduce amyloid accumulation in the brain, ultimately improving mental performance and treating someone with a combination of cholinesterase inhibitors and Memantine can enhance their cognitive function (Dou et al., 2018). Other studies to fully understand the key principles of Memantine, combined with Galantamine, have shown improved biochemical pathways in the brain, leading to similar cognitive improvements (Peters et al., 2012).

Although anticholinesterase inhibitors help treat AD, their efficacy for MCI is not well evidenced, and there are conflicting views on their effectiveness in treating MCI (Petersen et al., 2018). Albeit controversial, they remain widely used for MCI (Kasper et al., 2020). Other studies show insufficient evidence that anticholinesterase inhibitors prevent cognitive decline (Coupland et al., 2019; Pyun et al., 2021). On the other hand, in Copland et al.'s extensive study, researchers found that anticholinergic medicines were associated with an increased risk of dementia. Another study found that CIs have intolerable side effects rendering them unpopular, with problems such as nausea, vomiting, diarrhoea, and muscle spasms (Singh & Sadiq, 2021).

Much of the current research topic on MCI has focused on risk factors that may reduce the progression rate (Alzheimer's Association, 2020). Some research studies have demonstrated the efficacy of CLs in providing symptomatic relief for those experiencing MCI (Xu et al., 2020). However, for such treatment to be effective, it is essential to understand MCI, its root causes, and the underlying pathophysiological processes. For instance, one study found that Donepezil showed a slight but significant improvement in global impairment for people with MCI among depressed subjects (Lu et al., 2021). As well as improving cognitive symptoms, CLs can extend longevity (Xu et al., 2020). Successful treatment for MCI using CLs is worth considering, but more research is required to establish its effectiveness.

The literature shows that the estimated number of people with MCI regaining their normal cognition after MCI varies. Most importantly, treating the underlying causes makes it possible to reverse MCI to typical or near-average cognitive performance. Regardless of the effectiveness of CLs, people with MCI may have their symptoms reverse or improve over time by targeting the underlying physical or psychological causes (Karakaya et al., 2013; Koepsell & Monsell, 2012). However, the proportion rate may vary due to diverse medical conditions (Beard & Newry, 2013; Breitner, 2014). Specific conditions such as alcohol or drug-related cognitive problems, mood disorders, certain tumor types, chronic subdural hematoma, metabolic diseases, vitamin B12 deficiency and some infections of the central nervous system such as neurosyphilis and HIV are treatable, and this will reverse MCI symptoms (Singh & Sadiq, 2021).

Non-pharmacological treatment

Non-pharmacological therapy in treating MCI is another desirable option. Non-pharmacological treatment, such as lifestyle interventions, is helpful for most physical and mental health problems. For instance, cognitive behaviour therapy, diet, and physical activity have long been recommended for their health benefits and improving physical and psychological well-being (MOH, 2016b). Non-medicinal treatment has received more consideration and has proven to be favoured over the past two decades (Karakaya et al., 2013). For example, a specific focus on MCI education and promoting healthy lifestyle interventions are popular recommendations (Koepsel & Monsell, 2012). Similarly, non-pharmacological treatments, such as activities to stimulate the brain, are also proposed to improve cognitive performance, such as social interactions, hobbies, computer tasks, card, and board games, reading, and good nutritional support (Henderson, 2019; National Institute for Health and Care Excellence [NICE], 2018).

Moreover, the effectiveness of such interventions is uncertain or controversial (Wang et al., 2020). Some interventions rely heavily on health services and individual physicians (Mowszowski et al., 2010). On the other hand, non-pharmaceutical and preventive strategies can help reduce the impact of MCI, as described in the next section (Henderson, 2019; Wang et al., 2020)).

Impact of MCI

MCI causes cognitive changes that are serious enough to be noticeable by the individual or family/friends around them. The impact of MCI affects the individual’s ability to perform daily activities and causes long-term health problems. The effect of MCI linked to structural and functional disease changes is related to ageing populations (Beard & Neary, 2013). Although forgetfulness is understood to be a distinctive aspect of ageing, it should not affect the overall performance or ability of the individual to perform daily activities. However, MCI can affect their ability to learn new information and slow their mental processes and performance (Alzheimer Association, 2020). Being forgetful means, it takes longer to learn new things, not remembering information, the names of people and places, and losing or misplacing items such as keys/mobile phones (NIA, 2020). A person with MCI often forgets conversations and information they typically recall, such as appointments and other planned events (Alzheimer’s Association, 2020).

Physical and psychosocial impact

MCI in older migrants is a matter of global health importance, affecting the physical and psychological health of the individual (Xue et al., 2018). When older people migrate to another country, their health and wellbeing can be affected at distinct stages: pre-migration, early, and post-migration (Chu et al., 2022). Each of these stages can affect the typical ageing process, family dynamics, deterioration in physical and psychological health, and lead to poor quality of life and even higher mortality (Ganguli et al., 2011; Miramontes et al., 2015; Nikmat et al., 2015; Sood et al., 2019; Yu et al., 2019).

In the early stages of an older person's migration, they may experience increased mental distress (Chu et al., 2022). Older migrants are arguably considered healthy before moving to another country. However, their health may worsen, partly because of the stress of acculturation and complications with cultural understanding and linguistic barriers (Miramontes et al., 2015; Ramsey et al., 2017). Financial strain may also occur due to difficulties accessing healthcare services or health insurance (Hussin et al., 2019). Some migrants may have trouble living meaningfully because of these tensions, and over time, some might find this stressful, which may contribute to psychological problems (Beard & Newry, 2013).

Some older migrants may lose their ability to care for themselves and experience social isolation. A qualitative survey shows that older migrants experience a decline in social support, as well as a loss of roles due to early retirement and unemployment (Xu et al., 2017). Social disconnectedness is reported in the early stages of older migrants moving to an unfamiliar country. Cognitive problems also correlate with structural or functional changes in diseases associated with older migrants in such circumstances (Beard & Neary, 2013; Ganguli et al., 2011). One study reports mental deterioration, loss of dignity, and fearfulness of having dementia (van Wijngaarden et al., 2019). Thus, healthy ageing strategies to improve their cognition must be considered in the older migrant population during and after migration.

The impact of MCI is a common problem among older migrants after moving to an unfamiliar country, regardless of their age, gender, or health status (Xu et al., 2017) and may vary from person to person. However, someone predisposed to experiencing psychological problems may be more at risk. MCI can affect a person’s memory, language, attention, visual and spatial information processing, complex thinking functions, or a combination (Sood et al., 2019). Some older migrants may experience enduring emotional distress, life dissatisfaction, and social isolation, while others may be affected by physical and psychological health issues (Canevelli et al., 2020; García-Cid et al., 2020).

Families of older migrants with MCI may have difficulty caring for their family members and dealing with this disorder. An ethnographic study found that caregivers and family members expressed problems supporting their ageing parents who were experiencing MCI (Ramsay et al., 2017). This study reports low self-esteem, stigma, and stress as significant issues. Family caregivers and guardians often play a vital role in supporting others living in the community with illness or disabilities. In another study, changes in the family role are reported where family members see themselves as caregivers rather than as the children of their parents (van Wijngaarden et al., 2019). Other families report generational and identity conflicts, communication difficulties, family tensions, socio-cultural problems, and social isolation (Bustamante et al., 2017; Croston et al., 2009; LeMaster et al., 2018). If an older person with MCI needs care and health monitoring, the so-called “carer burden” seems to be a problem (LeMaster et al., 2018). Because MCI is likely to progress further, it can affect a person’s ability to self-care and need help. For instance, one study suggests that when older migrants need more care, home help, or admission to aged-residential care, it increases anxiety and stress within the family (Nikmat et al., 2015).

AD is one of the leading causes of disability, but before the individual’s health deteriorates, that person can live through years of morbidity as MCI progresses (Alzheimer’s Association, 2020). Moreover, morbidity and mortality can be familiar to those diagnosed with cognitive problems (Yu et al., 2019). The number of deaths due to MCI is often unrecorded in death certificates. A longitudinal study in the US found that 65% of 325 MCI patients developed dementia, and 24% died within three years of being diagnosed with AD (Yaffe et al., 2006). Of note, this study did not specify the number of people diagnosed with cognitive problems because psychological issues are not recorded on the death certificates as the cause of death. The cause of death is more likely to be registered as physical health than psychological (Contador et al., 2014). Studies show that older people diagnosed with cognitive problems may die sooner than others, while some can live with MCI for years without being affected (Hussin et al., 2019; Murray et al., 2005). In any case, the average number of people living with MCI may have their life expectancy reduced after being diagnosed (Xie et al., 2019).

Accessing health services

Older migrants' access to health services is complex due to cultural, institutional, financial, and other factors (Guo et al., 2014). Once older migrants settle in Aotearoa New Zealand, their extended families may need help knowing where to access proper support for cognitive problems and locating education on MCI (Cheung, 2010). Some migrants may need financial aid, and some may be excluded from social support because they are sponsored by their families (Te Pou, 2020). In Aotearoa New Zealand, newly arrived migrants may not have access to health care depending on their status. Many can only access emergency services but not specialized secondary benefits, such as memory assessment clinics, because of the immigration rules and visa status. Barriers may also include costs, lack of knowledge of health services and different sociocultural understandings of how and where to help them with their memory problems (Ho, 2004; Ramsay et al., 2017). Family members of older migrants are often confronted with significant socioeconomic difficulties (Beard & Neary, 2013; Nikmat et al., 2015). Such challenges hinder socialization due to memory problems, and their sociocultural upbringing prevents them from interacting with others.

Cultural differences, the inability to speak English, and limited knowledge or awareness of existing healthcare services are obstacles for older migrants in connecting with others and accessing necessary help for their memory problems (Ho, 2004; Guo et al., 2014). These issues and socio-cultural misunderstandings of customs, habits, patterns, and beliefs can affect older migrant groups if they are not acted upon promptly (Bustamante et al., 2017; Kohlenberger et al., 2019). Given that Aotearoa New Zealand has a substantial migrant population, it is central to better understand the impact of migration on mental health and socio-cultural wellbeing (Te Pou, 2020). For that reason, health services must work together with older migrants to meet their needs culturally and linguistically to improve access and ensure the provision of early intervention (MOH, 2020). Failure to do so can only lead to further cognitive decline. Another cultural factor to consider is the issue of social isolation for older migrants.

Social isolation

Social withdrawal from friends, families and shared activities among older migrants can lead to lower quality of life, psycho-social problems, and loneliness (Kirmayer et al., 2011). Studies report that when older migrants immigrate to join their children, they can become isolated from families or friends in their country of birth (Van Orden et al., 2020). As a result, separation from their siblings/family members is often associated with reduced family support and social networks. Furthermore, older migrants are less economically and psychologically unable to overcome the adverse effects of migration than younger migrants (Li et al., 2017).

Older migrants are more vulnerable because they are excluded from certain public services or cannot access specific community organisations. Literature also shows how low economic status contributes to social exclusion and defragmentation of social support networks can lead to poor self-esteem, depression, anxiety and memory (Mao & Zhao, 2012). Many experiences reduced social support from family or friends, ultimately leading to loneliness and negatively affecting cognition (Giles et al., 2011). The connection between social isolation and the mental well-being of older migrants has long been recognized as a fundamental health problem worldwide. Limited means and resources to connect with close relatives and friends can psychologically harm the most vulnerable older migrants (Arora et al., 2018; Beard & Neary, 2013). Older migrants must establish roots and bonds in the host country as a protective factor against social isolation.

Human beings need social ties to live and thrive. Social isolation can lead to loneliness, while others may feel lonely without isolation (NIA, 2020). International research reports that a connection between social isolation and loneliness in older people happens when social participation is reduced, which contributes to physical and psycho-social problems and increases mortality risk (Courtin & Knapp, 2017; Jamieson et al., 2018). Loneliness and its connection to cognitive decline are significant problems in older populations (DiNapoli et al., 2013). This impact can be experienced at different stages before, during and after migrating to an unfamiliar country. In an integrative review, Wright-St Clair et al. (2017) describes a link between reducing social networks and loneliness, which affect generational family changes and social relations. Another study shows the effect of loneliness on physical, mental, and cognitive health and later significant contribution to morbidity (Pyun et al., 2021). Kirmayer et al. (2011) report significant stresses related to loneliness, social estrangement, discrimination, and loss of memory function. It is important to note that the stress of migration does not cause MCI directly, but psychological problems such as stress and depression can lead to MCI (Ma, 2020).

Active engagement significantly impacts older migrants with MCI to reduce social isolation. It is essential to recognize that good connectivity, social stimulation and having friends or family around them can improve their cognitive health and quality of life (Nikmat et al., 2015; Wilks & Croom, 2008). Awareness of cultural knowledge is a fundamental approach to promoting social inclusion and reducing loneliness (NIA, 2020). In Aotearoa New Zealand, the MSD (2020) strategies recognize improving public health to promote social welfare and social inclusion for older migrants. This strategy is central because policies can shape how society works towards being more socially inclusive and measuring success (Henderson, 2019).

Progression of MCI

MCI is increasingly seen as a significant health problem associated with an increased risk of dementia (Jia et al., 2020). MCI is a heterogeneous condition in its clinical manifestations, and the aetiology shows that its progression has varying results. One study reported that the number of older people with MCI who develop dementia is much lower than those who return to normal cognitive health (Ganguli et al., 2011). Despite decades of scientific research, the debate about the progression of MCI continues. A long-running debate about cognitive impairment questions whether MCI is normal ageing or early stages of AD (Petersen et al., 2014). In fact, these are two categorically different diagnoses along a similar continuum, but those with MCI may not necessarily get AD (Ganguli et al., 2011; Spaan, 2016). Health professionals also consider that the connection between mood disorders, obstructive sleep apnea, excessive alcohol consumption, and stress contribute to the development of MCI (Henderson, 2019). I position myself with Henderson's opinion that psychological problems can lead to cognitive issues, such as MCI. However, to support this view, it is essential to consider that MCI could also evolve from brain disease, as mentioned earlier: amyloid plaques, tangles and tau being key factors (Lee et al., 2019; Lopez, 2013). This continuum is evident in scanning autopsies pointing to similar potential biomarkers used for MCI in medical imaging reports, which report that as many as 39% of all 1,337 autopsies had MCI, and 46.8% were diagnosed with dementia, whereas 13.9% had intact cognition (Abner et al., 2017).

There is enough evidence that cardiovascular risk factors and vascular pathology contribute to cognitive impairment (Lu et al., 2022). Vascular problems can contribute to the progression of MCI, and it is a well-documented process in which insufficient oxygen or nutrition damages blood vessels or neurons (Lu et al., 2022). As a result, cognitive problems are common due to such damage. As far as we know, vascular changes such as reduced blood flow to the brain or damage caused by multiple TIAs, ventricular shrinkage and drug interaction (Alzheimer's Australia, 2010). However, no single factors alone contribute to an increased risk of the progression of MCI to dementia (Lu et al., 2021). Notably, another study assessed the role of vascular risk factors, revealing no link between cardiovascular and MCI and the subsequent increased incidence of dementia (Xie et al., 2019). Note that modifiable risk factors such as high blood pressure, diabetes and depression are diseases that can contribute to cognitive decline (Campbell et al., 2013). Therefore, clinical interventions such as early diagnosis and prompt treatment can be meaningful in changing risk factors.

The rate of progression from MCI to AD varies from population to population and depends directly or indirectly on many factors (Jia et al., 2020). Another study suggests that the probability of progression is three to five times higher than those of developing dementia in otherwise healthy people (Campbell et al., 2013). Likewise, Jicha et al. (2006) found that in one-third of the population studied, people with MCI progressed faster to dementia. The findings of Jones et al. (1976) and Mufson et al. (2012) must be taken with caution, as neurological deterioration may directly affect or influence the progression and deterioration of MCI. One report also refers to conversion rates of 9.6% of those with MCI progressing to dementia over 22 years and up to 100% in four to five years (Elias et al., 2000). Conversely, one study considers the MCI cases reverting to normal cognition in up to 40% of the population (Ritchie & Touchon, 2000). Moreover, the return to normal cognitive function is another distinct feature distinguishing a person with MCI from dementia, an incurable disease (Ganguli et al., 2011).

Experience of MCI

Older migrants are vulnerable and experience significant challenges as they move from a familiar social and cultural environment to an unfamiliar country like Aotearoa New Zealand. While many have successfully integrated with the new host country, some experience significant difficulties such as access to health services, early retirement problems, loss of daily function and physical and psychological health problems. Various cultural factors may impinge upon MCI affecting the personal and social perception of individual cognitive functioning (Canevelli et al., 2020). Older migrants may experience a lack of understanding of what MCI means due to a lack of knowledge and a reduced level of insight into the condition (Berg et al., 2013; Johansson et al., 2015). Some people may view MCI as part of an ageing process, while others understand it as a medical or psychological problem. Others dispute evaluation techniques and long waiting times for a specialist appointment to clarify diagnoses (Moreira et al., 2019). However, once a doctor has assessed the individual, other issues of understanding the meaning of living with MCI surface. Some literature shows that older migrants perceive the diagnosis of cognitive problems such as MCI or dementia as a stigma and shame, and many criticise the assessment in memory clinics (Dean et al., 2014). Nevertheless, once diagnosed, some experience fears of its progression and the long-term prognosis and uncertainty of living with MCI (Michaud et al., 2017).

There is qualitative literature on the experience of community-dwelling individuals in receiving and adapting to a diagnosis of MCI (Berg et al., 2013; Ma, 2020; Portacolone et al., 2018). Morris et al. (2020) highlights people’s different experiences of MCI and elucidate the uncertainty, fears, and coping strategies accompanying a diagnostic evaluation of MCI. Some literature mentions the experience of anxiety, apathy and fear of getting dementia (Berg et al., 2013; Ma, 2020). In addition, a qualitative study highlights events that led to people’s diagnosis of MCI, such as experiencing memory loss over time (Portacolone et al., 2018). Similar uncertainties about being diagnosed with MCI were found in a Swedish study, revealing the inability of participants to cope alone and family concerns about cognitive changes while trying to be supportive (Johansson et al., 2015).

Experiences and perceptions of older migrants with MCI can raise various cultural issues. Diverse ethnic and sociocultural factors may affect their family and people’s perception of this condition (Canevelli et al., 2020). Due to misperceptions and cultural bias, some older migrants may be underrepresented in health systems (Canevelli et al., 2020). It presents a different challenge for the person who experiences MCI (Beard & Neary, 2013). One study found that older migrants experience uncertainty in a culturally diverse environment regarding accessing services and have difficulties accepting help because of their memory problems (Arora et al., 2018). Complications are also evident concerning managing physical and psychological health problems. There are concerns about the inability to continue working; some may retire early and fear that they will not be able to drive motor vehicles due to memory problems (Alzheimer's Association, 2020; Boustani et al., 2005; Celidoni et al., 2017). An Australasian ethnographic study reports significant socio-economic difficulties, social isolation, severe stress and cultural deregulation for people with MCI that can cause further psychological harm (Ramsay et al., 2017). In short, the complexities of older migrants' experience of MCI highlight the need for a greater understanding of what it is to experience this condition.

Psychological wellbeing

The relationship between migration and psychological wellbeing accentuates potential risk factors for older migrants. The possible psychological health problems affecting this group were discussed earlier. To reiterate, the number of ageing migrants in Aotearoa New Zealand is on the rise, and many suffer from psychological issues and are increasingly affected by MCI (Honkaniemi et al., 2020; Xue et al., 2017). Several studies have reported on the complex health issues of older migrants and their vulnerability to physical and psychological distress, which appears to increase because of age and time (Mirza et al., 2017; Peavy et al., 2013; Yates et al., 2017). There is anecdotal evidence linking such stress as an emerging risk factor to the development of MCI (Koyanagi et al., 2019; Ma, 2020). Coping with stress can vary from person to person. However, stress may come from frustration, life changes, and other physical or psychological problems (Xu et al., 2017). In actual fact, migration can also lead to stress-related issues and successful resettlement in an unfamiliar country (Brijnath et al., 2020; Xu et al., 2017).

The issue of psychological well-being cannot be overemphasised, nor its connection to MCI. Research by Cova et al. (2020) shows that older migrants with cognitive problems make up a considerable proportion of people attending memory clinics. They experience prolonged psychological distress and are increasingly vulnerable (Peavy et al., 2013; Sagbakken et al., 2018). Xu et al. (2017) perceived that stigma and lack of belonging in a foreign country can decrease social support and the size of social networks. Also, stigma may increase the likelihood of stress and psychological problems (Ramsay et al., 2017).

Cortisol helps regulate a wide range of vital processes in the body, such as metabolism and immune system response, which is a potential risk factor for easing stress (Hannibal & Bishop, 2014). Additional research reports that higher cortisol levels in the blood were linked to a high level of stress among older people without cognitive problems (Ouanes & Popp, 2020; Peavy et al., 2013). Mood and psychotic disorders have been associated with high-risk factors due to stress, affecting memory (Mirza et al., 2017; Wright-St Clair, 2015). Another retrospective study in Australia reports significant risk factors of stress for over 70% of the older migrant populations (Roughead et al., 2017). However, no studies link high cortisol levels in older migrants to MCI, but high stress can be an essential factor contributing to MCI (Ouanes & Popp, 2020). Thus, with the increasing number of ageing migrants in Aotearoa New Zealand and improving psychological wellbeing with age-related policies is needed to address this problem (Callow & Alpass, 2014; MOH, 2016a).

Acculturation stress

Acculturation stress is often associated with someone adapting to life in an unfamiliar country (Gruebner et al., 2017). Learning the language of a new country, establishing new social connections and developing cultural understandings can alter the psychological health of older migrants (LeMaster et al., 2018; Liu et al., 2020). Acculturation stress is a commonly observed neuropsychiatric feature of MCI linked to cognitive and functional decline (Ma, 2020). Much of the literature on acculturation stress is based on Berry's model (1997), which represents possible paths that migrants adopt when they move to a new country. Berry's model follows the willingness to relate to an earlier ethnic culture only (separation), new host culture only (assimilation), both (integration), or neither (marginalization) (Liu et al., 2020). These pathways vary in the older migrant demographic and are influenced by ethnic-cultural backgrounds and the reasons for immigrating within the context of acculturation of settlement in a settlement country (Lui et al., 2020). Based on this model, socio-cultural aspects and acculturation stress may affect the memory of older migrants. There may be social, cultural and spiritual issues which are prevalent when adapting to an unfamiliar country. These problems affect emotional intelligence (cognitive process), considered one of the most predictive factors in acculturation stress (Kim & Kim, 2013).

While adapting to new cultures, older migrants can also develop their coping strategies and use resources to deal with acculturation stress. However, some may be more vulnerable than others when adapting to or navigating a new country and its culture (Kim & Kim, 2013). Studies show that socio-cultural challenges contribute to the harmful effects on the cognition of older migrants (Kuo et al., 2014; Newbold, 2005). Similarly, other studies point to reduced quality of life and memory problems (Hsiao et al., 2016; Koyanagi et al., 2019). In contrast, the literature suggests it can positively change an older migrant's life and does not affect their cognition (Kim & Kim, 2013). To support this view, Tedeschi and Calhoun (2004) mention that older migrants can develop personal strength, seek new opportunities for life, strengthen meaningful relationships, value life, and improve spiritual growth.

Socio-cultural and spiritual factors

This section refers to older people with MCI rather than specifically to older migrants because of insufficient research on this population. Individual, socioeconomic, and cultural factors are significant issues for older people (Daly et al., 2015). Socio-cultural problems can impact health inequalities for some seniors, and many systematically experience more memory problems due to cultural influences (Curtis et al., 2019; Owokuhaisa et al., 2020). Ageing, and memory problems, can also be influenced by social-cultural factors. As Zhang et al. (2019) report, health disparities are common in older populations, increasing in most countries worldwide. Research in social science shows how ageing people from diverse cultural backgrounds are disadvantaged, have worse health, and have higher mortality rates (Zhang et al., 2019). Similarly, some of these factors can exacerbate the risk of MCI and dementia in later life, particularly in lower socio-economic groups who are disproportionately disadvantaged (Daly et al., 2015).

Social and cultural factors affect older people with MCI accepting care, assessment, and treatment (Owokuhaisa et al., 2020). Spirituality, religious affiliation, and cultural education create good health and well-being, including social support, which gives every culture existential meaning, a sense of purpose and a transparent moral system (Bozek et al., 2020). Conversely, such connections have shaped the social-economic environment, which affects the social fabric by improving physical and mental health (Gureje et al., 2015). Each culture has its interpretation and treatment of cognitive health issues, how they can be treated, and who should be involved. In some societies, memory problems are perceived as abnormal, while others perceive memory problems as a normal part of ageing (NIA, 2020).

Religious practices and traditions are mentioned in some Asian, Indian, and perhaps other cultures, such as the scattering of holy water, prayer, and other conventional healing methods, which can help manage mental health problems such as MCI (Weldeslasie, 2015). Early Chinese medical scholars also understood mental illnesses, or those with cognitive issues, to have contributing causes, such as an abundance of emotion, failure to control desires, and the depletion of “vital energy” from the body organs and the community to which they belong (Mcleod, 2017). Another study suggests the perception of satanic possession and witchcraft, which allegedly affects mental health and cognitive problems (Owokuhaisa et al., 2020). Literature also refers to Taoism, Buddhism and Confucianism philosophies, which have existed concurrently as the three main philosophical views influencing Chinese beliefs (Senel, 2020).

Philosophical beliefs also affect the well-being of older migrants with MCI, and personal views vary from culture to culture. Their distinct moral values, perception and understanding of cognitive problems in older migrants are significant considerations. It is also important to note that a psychological problem can have a particular cultural meaning. Taoism inspires people to take care of the natural world; their bodies and hearts should become a part of and belong to nature (Zhang & Veenhoven, 2008). While Buddhism advocates for the withdrawal of all earthly commitments, it has been closely intertwined with the practice of medicine in the mitigation and prevention of human suffering (Kalra et al., 2018).

On the other hand, Confucianism appears to offer guidance and advice in searching for happiness in present-day society, mainly because it recommends its followers to be involved in real, everyday family life (Zhang & Veenhoven, 2008). Confucianism sees every aspect of life as a commitment between people and entities, engaging in rituals to convey mutual dependence (Badanta et al., 2022). This philosophy offers wisdom for some Asian individuals who need care, support, and direction, particularly those with physical and cognitive health problems. It also helps healthcare professionals deal with a growing number of patients with different cultural and religious beliefs (Badanta et al., 2022). Alongside such philosophies, children are committed to fulfilling their roles and obligations with respect and kindness to their parents. Such perspectives also reveal the importance of filial piety as an essential commitment to obedience, devotion, and care toward one’s parents and older family members, forming the basis of individual moral conduct and social harmony (Li et al., 2021). Confucianism also emphasizes investing in social contacts, particularly familial ties, respect, good attitude and empathy towards older generations (Zhang & Veenhoven, 2008). When treating someone with memory problems, such a philosophy encompasses excellent esteem and love, offering care and support to an ageing family member (Woo & Mehta, 2017). However, one must be mindful of those who do not subscribe to this philosophy or belong to other faiths promoting similar philosophies.

Other migrant groups in Aotearoa New Zealand have similar philosophical or cultural values. For example, in particular Indian traditions, their children expect ageing seniors to be looked after when they experience physical frailty and memory problems (Partha & Khan, 2005). Indian culture, like many other Asian cultures, emphasizes filial piety, similar to the Chinese. As part of this cultural understanding, a son or daughter must respect and care for their parents. One of the core features of an Indian family has traditionally been three or four generations living under one roof, which is accepted as strengthening respect and love for the elders among the younger generation (Tiwari, 2013). Subsequently, when memory problems worsen for older family members, often their children may have to adjust and adapt their lives to take care of them. Unfortunately, this expectation can burden family members who must go out to paid employment and care for young children and ageing parents, causing antagonism and family discord.

A similar philosophical and cultural belief is held among some Pacific Island cultures. Pacific cultures are diverse, with distinct ideas, customs, languages, values, religious traditions and attitudes towards someone with memory problems (Sorenson et al., 2015). It can be challenging for health authorities to plan and provide appropriate services because of such philosophical and cultural beliefs. For example, in some traditional Pacific cultures, cognitive problems are believed to be spiritually linked (Kapeli et al., 2020). Spirit possession is seen as a culture-bound syndrome with mental, emotional, perceptual, and behavioural disturbances, including an altered state of consciousness, where the sufferer's mind is taken away by a spirit. Often the soul is unidentified, and sometimes it is a dead relative, and most sufferers of spirit possession experience the spirit as a vivid, imaginary companion who affects their memory (Vaka et al., 2020; Puloka, 1997).

According to Payman et al. (2018), it is reasonable to assume that older people of Pacific heritage may experience cognitive problems earlier than other populations. Caring for family members in some Pacific Island communities, especially those with mental health issues, is sacred. The traditional philosophy around duty of care brings blessings to the family; for example, it is the family member’s responsibility to care for the wellbeing and welfare of the extended family (Anae, 2017). However, it does not consider whether the individual has other family commitments or is working. Pacific philosophy stresses the importance of spiritual and cultural ideologies when working with older people with distinctive ways of managing psychological problems (Kapeli et al., 2020).

Moreover, traditional Samoan culture adopts the principles of Aiga, an extended family system led by a Matai (chief). Families usually live nearby and support each other (Anae, 2016). Matai emphasizes Aiga as an essential way to help those with health problems by implementing cultural ethics (Enoka et al., 2013).

Samoan beliefs also highlight the importance of taking time to build trust and rapport and an integral understanding of values such as ‘tausi le va’/’tuhi le va’ (nurturing associations) and ‘fa’aaloalo’/’faka’apa’apa’ (respect), which have explicit associations for interactions and engagement with an older person (Yates et al., 2021). So, from a Pacific point of view, providing healthcare to seniors involves understanding and conveying the principles of Aiga. Accordingly, to better understand MCI in the older migrant population, socio-cultural interpretations of memory problems must be considered in the healthcare system (Canevelli et al., 2020). Promoting strong family structures, hospitality, conformity, cooperation, and interdependence is crucial for older migrants and their families (Ramsay et al., 2017).

Spirituality and religious beliefs can influence people’s perceptions of someone with memory problems. In some religious beliefs, suffering from cognitive issues, such as MCI, is considered a punishment for past sins committed by a family member (Beznosova et al., 2015). Thus, this belief refers to the principle of the family sharing responsibility for the health issues experienced by one of its members. It is construed as a family problem rather than an individual one. The pathological disease state can be both a trial and a punishment for the offender (Krzysztofik, 2020).

Spirituality is a crucial cultural element in understanding the health and wellbeing of older migrants and the Indigenous populations (Beznosova et al., 2015). For older migrants, religion and places of worship are often a common source of support for family members (Koenig, 2012). Bożek et al. (2020) mentioned spiritual and health-related behaviours associated with psychological wellbeing. Other literature confirms the importance of spirituality and its positive effects on physical and cognitive health problems and links to wellbeing, quality of life, survival skills, and recovery (Koenig, 2012). It has been noted that Aotearoa New Zealand has become a very secular society in recent decades, that religious participation and the community involvement of religious leaders have declined (Oxholm et al., 2021). Despite this, some religious organisations still support people outside their congregations and mobilize psycho-social support and other resources for those with memory problems (Chu et al., 2022; Kirmayer et al., 2011). A place of worship can be a key source of support to help reduce stigma and discrimination against older migrants in some communities (Wright St Clair et al., 2017). Perhaps the relationships and embeddedness in church-based activities are essential for older migrants to feel a sense of belonging.

Stigma and discrimination

Public perception of mental health is a significant problem, as most stigma stems from fear and lack of education and understanding (Codjoe et al., 2021). The social stigma attached to the diagnosis of MCI can have similar extensive and lifelong effects on the individual or their family (Stites & Karlawish, 2018). As a result, MCI can hinder the daily lives and well-being of the individual, leading to depression, social isolation, and discrimination (Stites & Karlawish, 2018). People with cognitive problems may suffer from negative labelling in some societies worldwide (Phillipson et al., 2012). Older people compare MCI to dementia and consider it a death sentence (van der Steen et al., 2013). As a result, some experience reduced ability to carry out daily tasks or cannot contribute to a meaningful life because their condition is construed as a stigmatizing and incurable disease (Beard & Neary, 2013; van der Steen et al., 2013).

The stigma of living with cognitive problems poses considerable long-term challenges for a person and their family (Stites & Karlawish, 2018). The diagnosis of MCI can significantly and adversely affect interpersonal relationships and community interactions, leading to public fear and prejudice (Garand et al., 2009; Rosin et al., 2020). Experiences of labelling, separation, loss of status and discrimination within society are reported as cognitive problems in some cultures (Omori et al., 2014). Besides, negative connotations can prevent people from seeking early assessment and treatment, which may have long-term health implications (Hacker et al., 2015). One reason may be the greater prevalence of negative views of dementia, which makes accessing memory services more problematic, leading to delays in getting a diagnosis or using health and social services (Lee et al., 2019). In this regard, some memory clinics offer a less stigmatized approach to stigmatizing conditions, and people are systematically assessed, monitoring and evaluating health inequalities and outcomes (Curtis et al., 2019).

There are other concerns about prejudice and discrimination towards people with cognitive problems. In one study, a memory problem is regarded as a ‘shameful’ condition, and society perceives someone with this condition as dangerous (Makowski & von dem Knesebeck, 2017). Similarly, the study by Beard and Neary (2013) describes the family as seeing themselves as the victim of social stigma toward their ill family member. Friends of people with cognitive problems also report being alienated because of the social stigma related to those with such a condition (Garand et al., 2009).

Worldwide, perceptions and cultural views are changing for those with cognitive problems. Studies have shown less prejudice and discrimination in some cultures where societies with higher educational standards are better informed of such conditions (Stites & Karlawish, 2018). Other studies show more willingness among older migrants to identify a need for greater community involvement in health and education (Chu et al., 2022). People living with MCI, and their families, accept these cognitive problems, seek help and support from various health agencies and the community, and reject negative sociocultural attitudes (Alzheimer’s Association, 2020; Chu et al., 2022).

Summary

This literature review presented makes a particular connection between older people and MCI. This chapter highlighted research on MCI and identified gaps in knowledge, particularly for older migrants. In the absence of specific research on MCI, literature on dementia was explored to provide more context and background. The prevalence and potential risk factors of MCI were outlined. The assessment and treatment of MCI and the related progression of MCI were uncovered. Literature on the experience of people suffering from MCI and its impact/consequences on the inability to perform daily activities, affecting the individual’s physical and psychological health, was discussed. Social isolation and loneliness encapsulated the concerns of an older migrant and how MCI relates to migration. The psychological well-being of older migrants and the relationship to acculturation stress highlighted their vulnerability. The personal, social and cultural impact on the health and wellbeing of older migrants defined MCI as a genuine problem. Lastly, the relevance of philosophical values, stigma and religious beliefs as relevant issues in the health and wellbeing of older migrants with MCI was presented. The following chapter describes the research design of this study.

Chapter Three: Research Design

Introduction

The preceding chapter outlined a review of the literature addressing older migrants and their experience with MCI. This chapter presents the methodological and philosophical framework for this study. My journey to understand philosophical views is presented as a reference point for choosing my methodology and showing the justification behind the phenomenological position. Prominent philosophers Martin Heidegger, Max van Manen, Edmund Husserl, and Hans-Georg Gadamer, whose work influenced phenomenology, are discussed. Heidegger is the renowned philosopher chosen for this study due to his stance on an individual's lived experience. The general understanding is that human science assumes that the human experience of life is always more complex than a single description. Hence, there is always a component of this in the expression of life. This chapter defines the epistemological and ontological perspectives of the concept of ‘being’. I outline the central justifications that have influenced my phenomenological research position and examine my choice of this methodology to convey the richness of lived experience of older migrants with MCI. I present the rationale for using Heidegger's interpretation of hermeneutic phenomenology and how to better understand the phenomenon of lived experience by using Heidegger’s approach.

Phenomenology is about interpreting the phenomenon of the lived experience (van Manen, 2014). Phenomenological studies describe what people experience and how they experience a phenomenon. By examining an experience as individual life, new meanings and appreciations can be developed to inform or even re-orient how we understand this experience (Neubauer et al., 2019).

This chapter outlines the process of obtaining ethics approval from the Auckland University of Technology Ethics Committee (AUTEC) and seeking locality agreement on the study process from the two DHBs in Auckland. The selection of participants and the study population recruitment process are described in detail. The interview process, interpretation, transcription and analysis of the participants’ stories are outlined. Finally, this section shows the reliability and rigour of this study.

Methodology

Before starting this study, I had no preconceived idea of a suitable research framework. I explored all methodologies that best explore the research question: *“What is the lived experience of older migrants with MCI?”.* To my understanding, qualitative data help examine and provide deeper insights into the real world of a problem. On this issue, Parahoo (2014) explains qualitative research as an assortment of approaches with commonalities and differences. Qualitative research uncovers richer data about a person’s feelings or beliefs (Maxwell, 2018). Initially, several methodological approaches suitable for a qualitative research question were considered. Case study and grounded theory methodologies to answer “how” older people experience MCI were discussed with my supervisors. Case studies are ideal for analysing data that shape the choice of methods and link them to the desired outcome (Crotty, 1998). However, questions arose from a methodology that did not fully address the need to discover a person with lived experience, and a more appropriate methodological framework was needed. In further discussion with supervisors, exploring “lived experience” resonated well with phenomenology as it would provide better insight into peoples’ experiences of MCI. Hence, phenomenology was chosen to examine older migrants’ lived experiences.

Despite the usefulness of different approaches and philosophical bases, phenomenology is best suited to understanding lived experiences. It creates distinct ways of reasoning and investigating these experiences and points towards providing “opening, understanding and insights” (van Manen, 2014, p. 29). Hermeneutic phenomenology adds another dimension to this and is the preferred method of understanding lived experiences (Neubauer et al., 2019). Hermeneutics is also known as interpretative phenomenology, and it came from the work of Martin Heidegger (van Manen, 2014). Hermeneutics emphasizes discovery, description and meaning, rather than control and measurement, to give universal statements of scientific theory (Laverty, 2003). Hermeneutics allows the reader to judge the potential of the study to transfer knowledge to a particular situation (Maxwell, 2018; Seebohm, 2010).

The sharing of knowledge on a subject is interchangeable in hermeneutic phenomena (Maxwell, 2018). Over the past two decades, the philosophical tradition of hermeneutic phenomenology has permeated the building of personal and social theories (Domenici, 2008). The philosophical traditions of phenomenology, social constructionism and social constructivism are interlinked and are an essential consideration in this study (Flanagan & Flanagan, 2015). For instance, in theories of social experience, knowledge is built through interaction with others. Such experiences can help design and evaluate how knowledge is translated (Seebohm, 2010).

On the other hand, the theory of constructivism recognizes that researchers build new understandings and know-how by assimilating what is already understood about a subject. In developing constructivist philosophies, Bruner (1996) provides a framework based on the study of cognition, linking his work to various philosophical positions, especially epistemology, ontology, politics, and ethics. Such a framework relates to a crucial part of my grasp of the basic construction of personal knowledge.

Core phenomenological notions

From a social research perspective, phenomenology raises several questions about a phenomenon, and the researcher can draw conclusions from interpreting the qualitative data (Neubauer et al., 2019). In social research, phenomenological interpretation is a powerful methodological concept suited to exploring complex problems (Frechette et al., 2020). Individuals construct a narrative which allows them to remember a past event, recount it and consider what is meaningful to their experience (Benner, 1994). To understand this lived experience, the researcher listens to unearth what the participant cares about and understands their fundamental beliefs, assumptions, and interpretations (Frechette et al., 2020). van Manen (2014) guides us on making "empirical generalization" (p. 250) and knowing how the researcher comes to know the "Being of Things", which is how we know what we know. van Manen further refers to this phenomenon as the "phenomenology of practice" (p. 69), which shows that findings can apply to various subjects, especially health and education. In addition to comprehending the core notions of phenomenology, it is crucial to understand ontological and epistemological norms to implement phenomenological research successfully.

Epistemological assumptions

Epistemology is the understanding and explanation of how we know what we know (Crotty, 1998). My epistemological assumptions relate to studying knowledge that can be created, developed, and communicated to others. According to Denzin and Lincoln (2011), epistemological inquiry looks at the relationship between the knower and the knowledge and asks how we know the world. Epistemology is about how we make meaningful sense of our planet. The epistemological assumption for this qualitative study is that the researcher can get close to the participants being studied and learn from subjective evidence based on their individual experiences of living with MCI. In this study, the experiential knowledge can also be applied to older populations of different ethnic and cultural groups. A relationship always exists between the investigator and the phenomenon known or being discovered (Laverty, 2003). Older people will have specific experiences of a particular phenomenon and understand how they know things (Wright-St Clair, 2015).

Moreover, in seeking to gain that knowledge, epistemology explains how we know other theories, such as objectivism and positivism (Crotty, 1998). Epistemology asks how and why and describes a particular situation (Josef et al., 2013). The current study uses such an epistemological concept to allow the recollection of an individual's lived experience. The contextual knowledge from older migrants reveals its multiple stories and hidden layers. It is essential to see the data specific to each person with MCI as "culturally derived and historically located interpretations of their social-life" (Crotty, 1998, p. 67). This study recognizes how knowledge can be obtained in this interpretive research model, which significantly relies on interview skills, observational techniques, and narrative analysis (van Manen, 2014).

My previous experience being part of a community mental health team informs my epistemological perspective. I appreciate the knowledge and insight that can be gained by evaluating how and why things happen for an older migrant with MCI. In addition, and from an epistemological point of view, I explore the meanings associated with MCI and clarify its importance for the person in the context of Aotearoa New Zealand.

Ontological perspectives

Ontology is the study of being and questions the nature of existence with the structure of reality (Crotty 1998). My ontological position in this study refers to the relationship with the reality of the phenomenon of MCI. I consider my existence independent of this reality, and my knowledge contributed to the phenomenon. I base my ontological assumptions on what is characterized as “the nature of reality and the nature of the human being in the world” (Denzin & Lincoln, 2011, p. 183). On the concept of “being”, Heidegger (1962/2008) calls upon us to consider the dynamic interaction between the ontological and ontic dimensions of human existence. Likewise, van Manen (2014) suggests exploring the ontological assumptions connected with the notion of “spatiality”, which is the phenomenological existence of “being”. My ontological concept determines the “being” and classification of the phenomena of MCI (Heidegger, 1962/2008). Ontology research aims to better understand knowledge and inform theoretical prospects. An ontological perspective is a more personal expression of someone’s feelings; their genuine views offer a deeper understanding of the phenomenon being studied (Crotty 1998). However, it is crucial to understand that contextual factors can affect the interpretation of people’s views.

In this study, Heidegger’s (1962/2008) ontological concepts influence how research participants are addressed and interpreted. Heidegger cautions that it is “one thing to give a report in which we tell about entities, but another to grasp entities in their Being” (p. 63). From a phenomenological researcher’s point of view, I hear the ontological arguments of the participants when interpreting their lived experiences. My professional work serves as background familiarity for this research. However, I must put aside my professional perspective and recognize the ontological experience to eliminate bias.

Philosophical suppositions

This research reveals the experience of living with MCI among older migrants in Aotearoa New Zealand. As an emerging phenomenological researcher, I looked at the philosophical thinking of previous scholars and understood how their philosophies shape mine. Knowing how to interpret experience and appreciate philosophical stances is a crucial step. In essence, phenomenology is considered a philosophy, a method for examining a phenomenon of interest (Sloan & Bowe, 2014). As for understanding knowledge of a phenomenon, phenomenology supports an interpretation of the experience of human life, which is determined by interpreting human experience rather than simply illustrating views (Neubauer et al., 2019). For centuries, phenomenology has been used to explore meaning by analysing spoken language (Langdridge, 2007). Exploring language’s methodological and distinctive nature can separate phenomenological views into descriptive and interpretive phenomenology (Neubauer et al., 2019).

Heidegger (1962/2008) clarifies that interpreting experiences is not exclusively about identifying what one has understood but treating interpretation as its subject and not an auxiliary to studying something else. Heidegger posits that we meet each situation with a pre-existing assumption and better understand the phenomenon by developing a comprehensive philosophical framework. An essential part of phenomenology is the judgment and hypothesis that one brings when studying a phenomenon (Heidegger, 1962/2008). Thus, it is crucial to be familiar with and fully understand the philosophers who originally unravelled phenomenology. This is presented in the subsequent sections.

Phenomenology

Phenomenology studies explore what people have experienced in a phenomenon. Historically, in the early 20th century, Husserl, Heidegger, Gadamer, Sartre, and Merleau-Ponty contributed to the development of phenomenology. This methodology refers to the meaning and way we experience existence and understand ourselves in the context of the world we live in (Heidegger, 1962/2008). The focus is on shifting phenomenological thinking to give voice to the experience of a phenomenon. Under these circumstances, exploring the human perspective provides insight into the complexities and extent of peoples' understanding of the world around them (Sloan & Bowe, 2014).

As a research methodology, phenomenology is well-positioned to help health professionals learn from others' experiences (Neubauer et al., 2019). Phenomenology is ideal for this research because it involves open thinking, focuses on language, and stresses the importance of mindful engagement in daily life experiences (van Manen, 2014). The work of Heidegger influenced my philosophical insights into the concept of phenomenology.

From an anthropological perspective, the notion of phenomenology deals with both scientific and humanistic inclinations. Phenomenology strives to better understand a person's experience and acknowledge the nature or meaning of their "lived experience" (Creswell, 2013, p. 36). It emphasizes descriptive data as "a realm of significance" (Wisniewski, 2012, p.61). In this study, someone with memory problems has had a stigmatizing experience and associated it with mental health problems (Abdullah & Brown, 2011; Garand et al., 2009). Phenomenologically, lived experiences recognize the phenomenon as the "development of possibilities projected in understanding" (Heidegger, 1962/2008). Understanding the phenomenological experience of people with MCI is a step towards improving and creating social change. It is hoped that this study helps reveal the sense of "being" in the lived experience of an older migrant and discovers concepts that inform meaning related to living with MCI. Phenomenology helps raise that awareness and provide a voice for those older migrants.

The philosophers

Edmund Husserl (1859–1938) focused on the natural and social world as they appear in our consciousness (Husserl, 2014). Martin Heidegger, Max van Manen, and Hans-Georg

Gadamer also present other substantial and philosophical ideas for the phenomenological interpretation of human research.

Edmund Husserl

Edmund Husserl [1859–1938] is the father figure of phenomenology (Creely, 2018). Husserl began his profession as a mathematician (Polkinghorne, 1983) but soon became attracted to phenomenology, where he sought a universal foundation for philosophy and science (Laverty, 2003). Husserl was critical of the scientific method to understanding science by equally appreciating the objectivity and subjectivity of an individual's experience (Laverty, 2003). Husserl then excluded the absolute focus of positivism and accurate observations of external reality, arguing that phenomena are perceived by individual consciousness and should be the subject of scientific investigation (Neubauer et al., 2019).

Husserl's philosophy (1980/2001) was primarily epistemological because he believed that the subject of experience could not be separated from experience. Husserl's ultimate focus was on generalizations, possibilities and conditions for common essence that emerged through his own experience (Owen, 2001). In addition, his primary interest in studying the experience of things and human awareness focuses on understanding transcendental phenomenology (Wright-St Clair, 2015). The transcendental phenomenology of consciousness revolves around many objects and discovering things (Owen, 2001). Phenomenology can bring additional dimensions to the study of human experience through qualitative research. However, the later overview of descriptive phenomenology to explore a person's lived experience in social science research became more widespread (Husserl, 2014). Since then, researchers have widely used descriptive phenomenology in social science exploration to examine and describe lived experiences, which is best suited for the current study (Christensen et al., 2017).

Human consciousness is behaviour controlled by the brain, like any other form of perception. Husserl cultivated a philosophy that clarifies how human experiences are present in life (Spinelli, 2005). Indeed, phenomenology is a methodology that differs from the natural sciences and recognizes the human experience of matters or conscious beings (Husserl, 2014). Husserl sees people's experience and understanding of the world in their own vernacular as part of this philosophy. In social science, a phenomenological enquiry is considered a source of evidence beyond existing knowledge, but the phenomenological interpretation provides more in-depth and meaningful ideas (Rapport, 2004; Christensen et al., 2017). Still, the distinctiveness of Husserl's philosophy lies in accomplishing its true significance—penetrating deeper and deeper into the reality of the phenomenon (Sloan & Bowe, 2014). Husserl's descriptive philosophy has undergone many changes since its first conception and was further developed by Heidegger, Gadamer and van Manen. In this study, I examine how Husserl's philosophy has contributed to the complex human phenomenon of understanding scientific research.

Martin Heidegger

As one of Husserl's students, Heidegger [1889–1976] pioneered interpretive phenomenology after studying the epistemological way of understanding. Heidegger's (1962/2008) dominant philosophy was about the nature of the relationship between the knower and what might be known, an epistemological way to understand a phenomenon (Laverty, 2003). In his publication Being and Time, Heidegger challenges the existing phenomenological ideas of Husserl (2014), pointing to the descriptive nature of philosophy rather than focusing on the structures of awareness and interpretation. Interpretation explains the possibilities shown by Heidegger to understand a phenomenon. His position on interpretation highlights the potential of looking through an interpretive lens rather than a descriptive one.

Despite the popularity of his phenomenological approach, Heidegger was one of the most outstanding yet contentious philosophers of this century (Critchley, 2009). Before World War two, his political ties to the Nazi Party meant that he was a controversial character, although he later claimed that his philosophical views were not politically driven (Thomson, 2005). Despite this, there is still a widespread debate about his politics (van der Heiden, 2020). Thomson agrees that the thoughts and beliefs behind Heidegger's political association are minimalized, yet others trust that his philosophy is tainted. Heidegger's philosophy focuses on the existence of humankind in the social context of the world. While his supporters agree that understanding this political situation is indispensable, understanding the relationship between his philosophy and politics is just as central. The debate of whether Heidegger's philosophy aligns with Nazi ideology is significant to understanding his thoughts (Watts, 2011a). Some reject any link between his life and work as insignificant, suggesting that Heidegger's political affiliations and philosophical and moral character occur autonomously (Watts, 2011b).

Unlike other philosophers, Heidegger's (1962/2008) phenomenological theory still holds profound influence inside and outside the school of philosophy. While Heidegger's past associations may have undermined his philosophical work (Rose, 2017), it is not surprising that health researchers adopt his philosophy in clinical sciences (Dowling, 2007). His philosophical views have influenced architecture, modern art, social and political theory, psychotherapy, psychiatry, theology and other fields (Rose, 2017). In Heidegger's view, phenomenology provides a robust structure where the researcher can explore people's lived experiences as ontological concepts such as existence, being, and reality. In clinical settings, phenomenology is a popular choice for health researchers because it helps them better understand their patients' health. Thus, phenomenology can be explicitly applied to the experience of the first person of the disease to shed light on this experience and allow healthcare providers to improve their understanding (Carel, 2011). It may be helpful to illustrate the patient's experience of an illness through a set of phenomenological notions as described by Heidegger (1962/2008).

Regarding the current research, Heidegger's philosophy (1962/2008) can help better understand older migrants' experiences, which is an integral part of phenomenology.

Heidegger’s concepts of human existence may be related to the experience of health professionals in understanding the phenomenon of MCI. As an emerging phenomenology researcher, I recognize Heidegger’s thinking and consider the importance of interpreting the personal stories of study participants. My consideration of Heidegger’s philosophy gives additional strength and my knowledge of MCI. The human existence factor describes the need to open readers' eyes. This next section examines human concepts in the world.

Being in the world

“Being in the world”, “Being-with”, and “Being-one’s Self” are existential concepts defined by Heidegger (1962/2008, p. 41). They are based on a deep analysis of traditional existential notions and epistemological interpretations. Heidegger perceives the understanding of knowledge, experience and its meanings in being in the world of the individual. The interpretive position of phenomenology explains the concept of “being in the world” as Heidegger suggests the phenomena shows itself, which can be seen in how it appears in reality. Accentuating Heidegger’s stance, van Manen (2014) posits Heidegger’s methodological interpretation as an inquiry involving a dynamic play of “showing and hiding” (p. 28). When interpreting experiences, the researcher tries to understand and critique the basic principle of meaning associated with the phenomenon described. “Being in the world” allows the fundamental philosophy of being and the complex relationship between the world and the individual (Heidegger, 1962/2008, p. 41). “Being in the world” of someone with MCI is as though the individual is in a relationship with a phenomenon, and phenomenologically its existence depends on it. The next part explains “Being and Time” as another concept of “Being in the world” (Heidegger, 1962/2008).

Being and Time

“Being and Time” is Heidegger’s (1962/2008) way of looking into the meaning of “Being in the world” through an analysis of the experience of being human. Heidegger does not separate the philosophy of “Being and Time” from humanity, believing one cannot exist without the other. Heidegger’s philosophy suggests that one can only occur within human nature’s overall relationship of “Being and Time” (Watts, 2011b). The underlining structure of “being in the world” is like unitary authority and a complement to the “must be seen as a whole” (Heidegger, 1927/2011, p. 79). Heidegger reveals both “Being” and “Time” by presenting the concept of “the event of appropriation” to give his philosophical ideas more rationality (Heidegger, 1971/2001, p. 19).

Heidegger supports the view that time and human existence are closely linked (Heidegger, 1962/2008). According to Heidegger, we are in “Being and Time” because we are rational, social, practical and specifically effective as human beings who experience variable moods. He discerns that our philosophy is affected by time, human existence, and being in the world. “Being and Time” are closely knit, and he talks of how to find ourselves amid critical secular and social situations which touch us emotionally (Elpidorou & Freeman, 2015). From a phenomenological point of view, the nature of mood cannot be accepted without simultaneously defining the core of our existence (Heidegger, 1962/2008).

"Being and Time" shows that one should look beyond existence and explain the story by paying particular attention to the situation, time, event, and location. "Being and Time" stand for a robust ontologically based focus on discovering what "being in the world" implies (Heidegger, 1962/2008). Heidegger proclaims that "Being and Time" is an event not always planned or carried out by a person but an experience that previously existed. Moreover, the experience is always in the being of existence, in that we will look back to explain what it is from the perspective of the current situation. The goal is to attract the reader, not to convince but to offer an opportunity to think; no firm conclusions are drawn from a typical thought journey to new understandings (Crowther et al., 2018). Still, "Being and Time" can be taken for granted in an interpretation.

Heidegger (1962/2008) contends that though we understand the meaning of "Being there" or "Being in the world", the consequences may be obscure and ambiguous. Conferring to this philosophy of "let show itself" (p. 28), Heidegger contends that if "something that lies hidden but that belongs to what shows itself so essentially as to make up its meaning and ground" (van Manen, 2014, p. 33). This concept helps us understand Heidegger's philosophy about "Being and Time" and what may be hidden or concealed in a phenomenon.

In understanding a personal story, paying attention to words spoken and grasping their meaning may have distinct interpretations. The nature of the social world must be understood as experienced through an individual's eyes. The current study uses a phenomenological perspective of interpretation to capture what makes sense of the lived experience of older migrants. An anthropological understanding considers how "Being and Time" influence the researcher and how human beings experience an event (Heidegger, 1962/2008). The intention is to gain a deep understanding of the phenomena, considering the inherent characteristics of epistemology (Crotty, 1998). Crucially, Heidegger's point of view focuses on subjective experience, belief, and language. To better recognize the importance of "Being and Time", we must first understand in which context his account of "Being there" (dasein) is situated (Heidegger, 1962/2008).

Dasein

Heidegger's philosophy (1962/2008, p. 11) theorizes human existence as "Dasein", which he elaborates as "this entity which each of us is himself", an individual independent of their world. Heidegger suggests that dasein identifies a person as a particular entity, noting that we are all born with unique personalities with unique attributes and language. Dasein comprises specific objects with language attributes; that allow us to bring "inner" thoughts to the "outer" world to discover and experience (Wisnewski, 2012, p.73). For Heidegger, the key to understanding dasein is to look at the phenomenon and sense the meaning of the experience. Heidegger sees dasein as understanding humans experience a "bare world" and imposes a structured interpretation on it (Wisnewski, 2012, p. 71). Heidegger's assertions of this familiar way of thinking about the relationship of dasein to the entire world are an aspect of phenomenology that describes how our experience or interpretation is structured.

Heidegger's (1962/2008) concept of dasein is that our knowledge contributes to our understanding of the world. For Heidegger, dasein is a term that "picks out those beings who interpret themselves, who care about their existence, and who understand the world" (Wisnewski, 2012, p. 6). Investigating the meaning of being, Heidegger suggests we explore the very beings we are. Heidegger presents two basic structures related to the interpretation process: the "structure" (interpreting an entity as something for something) and the "fore structure", revealing the prior knowledge of dasein about entities in their world" (Heidegger, 1927/2011, p. 188). The primary concepts of dasein are not isolated, but "by the time we experience things, we are already in the world and how we are also influenced by life and being in it" (Parahoo, 2014, p. 217). By examining the structures of such an existence, Heidegger reasons that we can restore an understanding of the world we have forgotten—we can become cognizant of what it means to be (Wisniewski, 2012). Although Heidegger's understanding and interpretation of the world relate to dasein, his notion of thrownness shows another objective existence.

Thrownness

Thrownness is a notion introduced by Heidegger (1962/2008) to describe the individual existences of humans as being "thrown" into the world. Thrownness is the English translation of the German word "Geworfenehit"[1], an ontological phenomenon of "being in the world", like the term "fallenness"[2], which is another existential concept of Heidegger (1962/2008, p. 32). Thrownness is a central feature of individual human existence as the concept of being "thrown" into the world (Horrigan-Kelly et al., 2016). Based on Heidegger's notion of dasein, life possesses a triple structure—past, present, and future; the historical past is characterized by the thrownness associated with "Being and Time". Critchley (2009) suggests that being "thrown" is a simple awareness that we are always everywhere, namely a world we are intrigued by or a world we share with others. Thrownness can explain existence as being thrown into situations that captivate it. Thrownness is an awareness of finding ourselves 'somewhere', capturing something essential about the human condition (Cowles, 2017).

Death is central to Heidegger's concept of human existence (1962/2008). In "Being and Time", he presents that awareness of death allows human beings to experience true freedom and determination. Addressing and understanding the ending is paramount to living an authentic human life. Making sense of death is to understand life. The significance of dasein in "Being and Time" is also about 'being towards death, which occupies a prominent position in

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[1] Geworfenehit is another notion of Heidegger's showing alienation or limitation that people are struggling with a traditional pattern of responsibility (Heidegger, 1962/2008).

[2] According to Heidegger, Fallenness signifies the primary being that belongs to the everyday world. Fallenness is the daily mode of being human within their everydayness.

Heidegger's reflections on authenticity. "Being and Time" occurs when the dasein confronts its finite nature by resolutely accepting the journey towards its end. Human mortality raises being thrown into an equally inconvenient situation. If the being is endless, then authentic human life can only be found by facing finitude and making sense of the inevitability of death (Critchley, 2009).

Hans-Georg Gadamer

I refer to another phenomenological philosopher whose philosophy influenced the interpretation of lived experiences. Hans Georg Gadamer [1900–2002] was a student of Heidegger in the mid-1920s. Husserl and Heidegger inspired Gadamer, whose work developed into the more practical application of "hermeneutic" phenomenology (Polkinghorne, 1983). Gadamer's philosophy has been widely used as a theoretical and methodical framework for interpreting a phenomenon (Laverty, 2003). According to Gadamer (2004/2013), all knowledge includes prejudice, which is deeply rooted in historical consciousness and can affect understanding. In Barthold's (2020) view, Gadamer's philosophy implies that we might never thoroughly think about ourselves in situations that we cannot change and challenge our beliefs. The supposition is that background knowledge raises questions or interests, and all successful efforts to revive the past require changing it to make it relevant in the current context. Likewise, Gadamer (2004/2013) emphasizes the importance of dialogue and understanding the phenomenon by interpreting an experience. Gadamer posits the concept of "historical consciousness" as a thorough consideration of the history, culture, and politico-social environment in which the study is located (p. 312).

Hermeneutic phenomenology

Hermeneutic phenomenology is a philosophy influenced by Heidegger and Gadamer, who sought to describe and interpret life experiences (van Manen, 2014). According to van Manen, hermeneutic phenomenology is a "pre-reflective experience that carries the capacity to cultivate ethically sensitive understandings and morally appropriate actions" (p. 280). Gadamer's (2004/2013) interpretative lens is similar to Heidegger's but focuses on how language is philosophically revealed through initial hermeneutic theories. He also recognized the circular notion of moving between some texts and the whole part of the story. Furthermore, van Manen considers insight into what happens across vocabulary, comprehension, and interpretation, which are intricately connected (Langdridge, 2007; Sloan & Bowe, 2014).

Hermeneutic phenomenology aligns well with Heidegger's philosophies because it provides concepts or notions as abstracts of the interpretive descriptions which cannot be generalized (van Manen, 2014). Unlike descriptive translation and interpretation, it is not always possible to initially plan research in hermeneutic phenomenology, as the researcher must respond to what is learned from the individual (Taber, 2013). Notions, rather than themes, create a platform to reveal connotations of what is or is not hidden to others (Heidegger, 1962/2008). Crowther et al. (2016) suggest developing interpretative accounts of stories from transcripts to open dialogue with other like-minded researchers and provide alternative opportunities for traditional ways of dealing with qualitative data. Instead of making general assumptions regarding philosophical foundations, the essence of hermeneutics is to highlight what is taken for granted. Hermeneutic phenomenology is about understanding the richness of qualitative data and stories of hidden phenomena (Crowther et al., 2016). Ultimately, it is essential to constantly pay attention, reflect and ruminate to discover the meaning of what it is like to experience MCI.

This study enables participants to share personal stories of their experiences living with MCI, and the researcher offers a hermeneutic account of that experience. The basis of hermeneutic phenomenology is that the two schools of thought have grown from a common idea and inspired each other. Hermeneutic phenomenology is relevant in this study as it explores the lived experiences of a particular phenomenon and provides an interpretation of the experiential meaning (Wright-St Clair, 2015). Hermeneutics treats the understanding of the lived experience as a primary concept rather than supplementary (van Manen, 2014). Gadamer believes hermeneutics begins when the researcher's knowledge moves with a deepening sense of the interconnection of the experience (McCaffrey et al., 2012; van Manen, 2014). Next, the researcher sees the world by interpreting stories about particular life events and the reasons for the interpretation and understanding. While the hermeneutic methodology is essential and an effective way to analyse a person's stories, I found van Manen's interpretation of lived experience easier to use.

Max van Manen

Max van Manen was born in the Netherlands and has come to prominence since the 1970s. His philosophy unites the theories of Gadamer and Heidegger (Brown, 1991). While Gadamer's philosophy focuses on dialogue, understanding and experience, van Manen believes that human existence exists close to understanding individual beliefs (Laverty, 2003). His philosophy is regarded as a "sequel" to Heidegger's thinking (Wisnewski, 2012). van Manen also believes we should look at the very existence of who we are as human beings and next to a world we do not differentiate ourselves from (Wisnewski, 2012). Phenomenology is about "listening closely to the words" expressed by the person, which may have a "specific rational sense" (van Manen, 2014, p. 57–61). The philosophical viewpoints on a person's position offer solutions to interpreting their stories (van Manen, 2014). Phenomenology provides a practical and rigorous way of understanding human phenomena, allowing research on the most sensitive and decisive aspects (Errasti-Ibarrondo et al., 2019). van Manen's philosophical position on hermeneutics provides a clear insight into interpretation, and his position on historical and cultural contexts provides a basis for understanding the person through the corresponding lens of the interviewer (Langdridge, 2007). In this sense, the primary purpose of the researcher is to "delve deeper or better to explore the experiences of life more concretely" (p. 66). The challenge is to make phenomenology "accessible and doable by researchers who are not themselves professional philosophers and who do not possess an extensive and in-depth background in the relevant phenomenological literature" (van Manen, 2014, p. 18).

In choosing hermeneutic phenomenology, I have considered both Heidegger's philosophy and referred to the views of van Manen (2014) as a practical philosophy for this research. His philosophy offers an outstanding phenomenological text that improves our understanding of a person's daily life experience, and he suggests that "in writing, we can deepen and change ourselves in a way that we cannot predict" (van Manen, 2014, p. 20). Thus, a deeper understanding of his philosophy can help researchers understand more about hermeneutic phenomenology.

Method

This section describes the process I have undertaken to conduct this study. In choosing hermeneutic phenomenology, I realized I had to stay close to the philosophical foundations of Heidegger (Heidegger, 1962/2008). Earlier, I described how his phenomenology inspired me to enter a world of interpretation of lived experience. I will continue to present the chronological process of how this research method was performed and how I see meaning in the text. Phenomenology as a method is reflexive and involves the practice of "ontological reduction", returning to the world as it was lived by the individual (van Manen, 2014). In the next section, I will uncover my presupposition interview, ethics approval, recruitment of participants, data collection, interview process, data analysis and transformation, and rigour.

Presupposition interview

My preunderstandings are essential considerations before data collection because they exist before the process of understanding and influence emerging understandings. Therefore, reflexivity is a central aspect of that preunderstanding, as this is the starting point at which proper understanding begins (Maxwell et al., 2020). Before interviewing the participants, I had an interview with my supervisors in November 2018 to determine what led me to study older migrants with MCI and explained how and why this was significant. This interview was crucial to ensuring that my personal and professional background and expression in this discourse would not reflect potential bias. After analyzing this interview, I reviewed the feedback received from my supervisors and included suggestions to improve how to conduct interviews with participants. Their input was geared to ensure I understood my role as a phenomenological researcher and the impartiality of doing this research with the selected population.

The presupposition interview recognizes what I understand about MCI and my assumption about people living with MCI. Another premise is that potential participants would know more about the phenomenon being studied. This can give the impression that their cognition does not interfere as much as it seems. However, such assumptions and interpretations must be considered for the purpose of this study. It is also vital that there is no prejudice or that the participant's data is not distorted.

Lessons learned from this interview enabled me to think about my previous mental health practice, which could benefit me as mental health nurse and exposes the "biases, assumptions and theories" of a researcher (van Manen, 2014, p. 347). It was essential to recognize this and clarify that I am studying this phenomenon as a hermeneutic researcher, not a mental health clinician. It does not mean that I am an expert investigator in personal communication with people with MCI, though I have the upper hand in understanding the condition before interviewing anyone. Pre-conjecture of knowing too much or too little can come through professional experience or concepts of common sense understanding in this world (van Manen, 2014).

Ethical considerations

This study has required ethical approval because it involves human subjects. Ethical consent is necessary to reduce potential psychological harm to participants and to obtain informed consent from a person with MCI. Before commencing this research, I consulted my supervisors, the two DHBs research offices and a representative from AUTEC to seek advice on related ethical issues (see ethics application in Appendix A).

This study also required a locality arrangement with DHBs where potential participants would be recruited. Local agreements were needed because the intention was to recruit older migrants in the two Auckland DHBs catchment areas. Both were contacted, and approval was granted by the Ko Awatea Research Office of Te Whatu Ora Manukau, formerly Counties Manukau District Health Board (CMDHB) (see Appendix B) and Awhina Research Office of from the Te Watu Ora Waitemata, formally Waitematā District Health Board (see Appendix C).

Ethics approval included a participant information sheet (Appendix D) to provide detailed information for prospective participants. Second, a consent form was included for the audio recording interviews (Appendix E). Information given to all participants was that they were fully informed of the participation process and agreed to take part, or they could refuse. All the implications and reasons for the selection of participants were made available. Ethics approval ensured discretion and confidentiality for all participants. In that process, a transcriber was required (Appendix F). Pacific Island, Korean and Chinese cultural advisors were consulted on specific cultural issues that arose in the interviews (Appendix G). Mandarin and Korean language interpreters helped with the translations (Appendix H). Participants were given pseudonyms; subsequent use of personal information and place names were changed on all forms to protect confidentiality.

Recruitment of participants

Once the ethics approval and locality agreement were granted, I started recruiting participants. A purposeful sampling method was used to help with this process (Schneider et al., 2016). This is a well-specified process in which the researcher can select members who meet the inclusion criteria or have specific knowledge of the topic (Schneider et al., 2016). Participants of all genders and ethnicities lived in their homes in two of Auckland's geographical areas.

Initially, I approached the relevant team managers of the health of older people services in Auckland. I then contacted the respective team leaders, clinical nurse specialists and geriatricians by phone, email and letter. I sought the approval of the service manager to display posters or send an information pack to those willing to become involved. I asked the relevant health professionals to share some flyers and help disseminate information about this research to outpatient clinic customers and potential participants who met the criteria. Most of the communication was through email or a visit to staff offices. Subsequently, I emailed the professionals an information pack about the study and availed myself if anyone sought further clarification.

Despite these efforts, the process did not yield any referrals from the DHBs. Information conveyed to me suggested that most of those referred to secondary services had a more advanced memory loss and were, therefore, unsuitable in meeting the criteria for MCI. I, thus, expanded my campaign to recruit participants by engaging with various Non-Governmental Organisations (NGOs) and contacting several ethnic community centres such as Alzheimer’s Auckland and Age Concern Auckland. I also approached local libraries, community-based organisations, and social clubs/religious groups where older migrants gather. Posters advertising the study (Appendix I) were displayed on notice boards in those NGOs, providing study details and my contact details. Replies received were acknowledged with a letter of thanks for their interest, and an invitation to meet was sent.

Once I had received several replies from potential participants, an information pack comprising the participant information sheet (Appendix D), a consent form (Appendix E), and a stamped addressed envelope was sent to them. Upon receiving the signed consent forms, I called to invite participants to attend the interview at a specific time, date, and preferred location. Those who responded to local posters were asked to confirm that they had mild memory problems and were diagnosed professionally by a doctor. It was expected that participants meet the inclusion criteria (see the next section) of MCI for the interview. Each participant was offered a koha of $40 for their contribution to the study (Appendix J).

Participant selection

I sought participants in the Auckland area who could provide me with informed consent to participate in this study. The goal was to include older migrants who could engage in meaningful talk about their memory and their ability to share lived experiences without coercion.

The inclusion criteria for participation were:

- People aged 55 years or older who had immigrated to Aotearoa New Zealand, over the last decade.
- People diagnosed with MCI at least a year before this study started were confirmed to have MCI by their GP as stable.

- People who lived in a community-dwelling in the two catchments area of Auckland DHBs.
- People capable of engaging in a conversation in English or their respective language.
- Able to provide informed consent.

The exclusion criteria were:

- People with severe cognitive impairment before or after coming to Aotearoa New Zealand.
- People with schizophrenia or mood disorders.

This study explores the lived experience of older migrants with MCI through individual semi-structured interviews. Eighteen potential participants approached me, and three were deemed not to meet the criteria for inclusion. In the end, fifteen participants took part in the data collection as stated below:

Participants profile

The study involved 15 participants from different ethnic and socio-cultural backgrounds. All participants were interviewed alone, except for Sam and Ida, who had their partners with them. The same Mandarin interpreter translated for all the Chinese participants. A Korean interpreter helped interview the three Korean participants (see interview structure further). Cultural advisors were consulted after the interviews.

Table 1

Participants' profile

Pseudonym	**Age**	**Status**	**Occupation**	**Country of origin**	**Interpreter/ Language**
Maya	68	Married	Retired	Hong Kong	English
Catherine	72	Widow	Retired	China	Mandarin
Tracy	81	Married	Retired	China	Mandarin
Mary	78	Widow	Retired	China	Mandarin
Kate	81	Widow	Retired	China	Mandarin
Eileen	79	Widow	Retired	China	Mandarin
Susan	79	Married	Retired	China	Mandarin
Anne	83	Widow	Retired	Korea	Korean
Lynette	76	Widow	Retired	Korea	Korean
Joan	70	Widow	Volunteer	Korea	Korean
Gemma	72	Separated	Retired	Brunei	English
Sam	60	Married	Bus driver	Samoan	English
Ida	56	Married	Supervisor	Tonga	English
Audrey	78	Widow	Retired	India	English
Charles	67	Married	Retired	S. Africa	English

Cultural and linguistic barriers

Cultural values are an imperative consideration for this research. The possibility of getting to know the context of someone’s life during an interview can also redirect researchers’ understanding of aspects of human development and behavioural patterns arising from cultural practices (Pessoa et al., 2019). In this study, it was crucial to understand that all participants were older migrants and that their cultural diversity could affect the translation and interpretation of their experience. English was one of the few languages, but its linguistics added complexity and potential communication barriers. Understanding the languages and cultures of participants posed a dilemma in interviewing older migrants, as well as considering that they all had memory difficulties. From a layperson’s point of view, it was important to ask questions clearly, and in a language, the participants felt comfortable with.

Regarding language, Heidegger (1962/2008) points out that people can produce and even change the language environment by engaging with the individual. This research involved using an independent interpreter to translate the stories and reduce cultural prejudices. The same translator attended the interviews (within the same language group) and translated my questions from English to the participants' language. After the interview, I consulted cultural advisors to better understand the issues that surfaced during the interviews. In the interview process, I asked the participants questions in English about their lived experiences. The interpreter then converted the questions to the participant's language (Mandarin or Korean, see Table 1). As soon as the participants responded, the translator simultaneously translated the answers.

Sometimes there was a combination of translation and interpretation when the participant's answers were vague or did not fully answer the questions. In such cases, the translator would clarify if they used interpretation. This process also added reliability and validity to participants' interviews. The combination of the interpreter and consultation with the cultural advisor helped capture the participants' experiences, which allowed the researcher to understand their experiences and appreciate their cultural values.

Informed consent

Voluntary informed consent was required from each person taking part in this research. It is challenging to get the consent of someone with MCI due to doubts about their mental abilities, and they may have slight or marked cognitive decline, such as memory recall, compromised thinking skills, and limitations in functional abilities (Alzheimer's Association, 2020). However, it cannot be assumed that those with MCI do not have the mental capacity to consent to research unless they are deemed unfit by a doctor. For this study, I determined the ability of participants to grant consent based on their doctor's assessment. Participants fully understood the reasons for agreeing to participate in the research and consented to participate in face-to-face interviews.

Managing participant's anxiety

Anxiety is a natural human reaction and a vital part of our lives (Chand & Marwaha, 2020). Managing participants' anxieties is a significant consideration in research (Batista et al., 2020). As a mental health nurse, I have experience working with older migrants with MCI and dementia. I viewed the participants' condition of MCI differently from that of dementia. I looked at the experience of memory problems as a researcher, not as a clinician. Reducing anxiety was crucial to ensuring that participants did not feel pressured to answer questions that were considered too stressful, complex or would potentially cause discomfort. In order to manage this problem, adequate prevention or rehabilitation strategies must be implemented. Knowledge of positive and protective approaches was implemented to address such fears. Therefore, I would have stopped the interview if I had noticed any anxiety-causing questions. I explored whether a question had caused discomfort and provided proper support and assurances as identified in the participant information sheet. If the participant did not speak English, I asked the translator to clarify the issues with the participants. After the interviews, I checked the wellbeing of the participants and asked the interpreter to help me better understand if there were any concerns.

Phenomenological interviewing

The interviews were recorded using two recording devices, a digital voice recorder and a cell phone as a backup. The anonymity of the data gathered has been preserved by using pseudonyms. Participants' original transcripts, consent forms and correspondence were stored on a portable, password-protected hard drive, now secured in a locked closet at my residence. All other sensitive data is stored the same way and will be destroyed after six years. I conducted the interviews in quiet, private rooms in three community associations, where most participants regularly participated in weekly activities. Three other participants were interviewed at their residences. The AUT research safety process outlined that I contact my supervisor before and after each interview. I followed this rule, and there were no concerns about this process, which took several months to complete. In ensuring the privacy of the participants, I also assured them of the privacy process of data collection in the participants' information sheet.

Before the interview, I read the consent forms aloud to each participant to determine if they needed further clarification and asked if they still agreed to participate. Once each participant consented, a mutually convenient day, time and place were arranged. I then interviewed them individually, which took about 60 to 90 minutes. I conducted all the interviews in just over six months.

On the interview day, I greeted the participants and ensured they were comfortable before starting the interview. I fully briefed participants and interpreters on the interview process before collecting data. In line with the ease of contact with participants, help from other essential family members or friends was allowed. Two participants, Ida and Sam, asked relatives to support them. Consent forms (Appendix E) were gathered on the day, and I ensured the participants had signed them. I reaffirmed their right to stop or withdraw from the interview if they experienced physical or psychological discomfort. As a researcher, my duty was to provide support or directions if help was needed. I would have offered help if such issues arose and pointed to the counselling services available through AUT Health, Wellness and Counselling Centre, and other Primary Healthcare Organisations. This step is vital because of the challenges of living with MCI and feeling uncomfortable talking about memory loss. Despite these assurances, no participants asked for further support, and none withdrew from the study.

Interview process

A semi-structured interview process was used to collect data from the participants. Semi-structured interviews help recover stories behind respondents' experiences or when minimal information is presented. Some predetermined questions (Appendix K) were set up to collect data based on the study method. During the interview, I asked broad questions to engage the participants informally, openly, and in a friendly way. I then probed with further questions and explored inconsistencies to gather more detailed information about shared stories.

I chose questions based on their relevance to MCI and as per the hermeneutic methodology. Hermeneutics is aimed at the question of the meaning or sense of being. An inquiry into the question begins with what human beings make sense of and can be said to be or exist (Heidegger, 1962/2008). Participants must be geared towards the subject and the interviewer to make sense of their stories. Engaging in a hermeneutic position allows for conversations and connections to the story (Vandermause & Fleming, 2011). Participant interviews are best conducted informally and in a conversational style (van Manen, 2014). However, the hermeneutic interviewing process requires the researcher to be reflexive, explore participants' experiences, and ask more qualitative questions for richer data. Reflexive interviews allow participants to signal an agreement, propose changes, disagree on interpretation, supplement the information, or clarify obscure points between the interviewer and the participant (Pessoa et al., 2019). That allows the interviewer to respond better if the participant becomes unnecessarily anxious or uncomfortable; the interviewer takes cues from the participant as the interview progresses (Vandermause & Fleming, 2011).

Reflexivity

Reflexivity is to determine any personal beliefs or attitudes that may affect the research process; an essential skill is required to engage in a culturally safe practice (Dawson et al., 2022). My experience conducting face-to-face assessments as a psychiatric nurse has helped me better understand answering open-ended questions. Often overstructured questions can also miss hidden meanings of the story (Wright-St Clair, 2015). The questions that phenomenology can answer and the ideas that this type of research can provide are fundamental to health professionals and researchers (Neubauer et al., 2019). van Manen (2014) suggests a strong orientation toward the research question, not to get side-lined. Simple open questions were encouraged, remembering moments and events when memory problems existed and encouraging participants to give meaningful answers. It was also a friendly way to engage and question by recalling moments and events from daily life. “Questioning and questioning further” can produce qualitative data allowing the respondent to speak freely and choose to use their own words (Wright-St Clair, 2015, p. 54). This mode of questioning helped me develop a genuine sense of the participant's first-hand experience of memory problems. It also allowed for a deeper understanding of their life experiences.

Interview structure

For seven participants, English was their second language, so I recruited a Mandarin interpreter, and for three Korean participants, another interpreter was used. Typically, I would start the conversation in English, and the interpreter would translate my words. At the beginning of each interview, I explained my professional background, confirmed why I was doing this research, and verbally assured them of confidentiality and their right to participate or withdraw if they felt uncomfortable or were unwilling to answer my questions.

Having summed up the points, I often asked them to repeat or ask the translator to seek clarification and encouraged them to share their stories more deeply. This way, participants became more involved in the interview by using reflective listening skills and attending, responding, and summarizing. I reacted and often used a teach-back model to assess participants' understanding and reteach or modify the questions when knowledge was not demonstrated (Yen & Leasure, 2019). With this technique, I would ask the translator to ask the participant to repeat the question to check if they understood what I had said, which showed active listening. Answers and meanings were carefully listened to, and handwritten notes were taken. This step proved significant in verifying the information and helping explore the phenomenon (Sloan & Bowe, 2014). If participants did not recognize certain words, clarification was used to demonstrate participants understanding.

I started each interview with simple personal questions and gently moved on to question them about their memory. I was determined to approach conversations in a way that encouraged rich phenomenological stories. Sample questions are below:

- Please tell me about the time when you were diagnosed.
- Tell me how you live your daily life because of your memory problem.
- Tell me when your memory started affecting you.
- How did it feel when you became aware that you had memory problems?
- Tell me about a period when your day did not go well because of your memory.
- Tell me about a period when things went well.
- Tell me about your culture and how memory problems are regarded.

After each interview, I briefly reviewed the transcript to determine how the participant answered the questions. I also consulted my handwritten notes to verify that everything was recorded accurately. This information was essential for preparing for subsequent interviews. Minor alterations were made to emphasise open-ended questions and ask questions starting with ‘tell me more’ on particular responses given. For subsequent interviews, I pointed out words that needed further clarification, such as MCI, dementia, and other medical terms. I used the same interpreter for the rest of the interviews. I thanked all the participants who had freely given their time and shared their stories. I reaffirmed my appreciation for their contribution and how the results could improve the lives of migrants with MCI. All participants accepted the koha of $40 for their contributions.

Data analysis

Transcribing interviews

All interviews were digitally recorded and backed up by a secondary cell phone. I started by transcribing the first conversation, and the subsequent one was sent to a transcriber. Sending recordings to a transcriber helped me maximize my time compiling stories and analysing the data. When the transcripts arrived, stories of a lived experience were read and reread in the hermeneutic process of interpreting the text for the meaning of their daily experiences (van Manen, 2014). The first transcription helped familiarize me with the process and the close relationship with the spoken word. There were difficulties due to inconsistencies in recording quality, and sometimes background noise interfered with accurate transcription.

Participants sometimes shared information unrelated to interview questions regarding a family member with mental health problems. I deleted these comments to maintain consistency and relevance to the questions raised. I regularly clarified verbatim, and interpreters filled in incomprehensible words to add context to the voice. When phrases lacked clarity, I added prepositions or nouns to improve expression. After the first draft, I returned the transcripts to the participants to verify their integrity, corrected all the changes, and rewrote the draft.

Professional bias

As professional researchers, the human mind may be biased toward a problem. Hence it is imperative to have a phenomenological reduction or bracketing process. Laverty (2003) suggests that researchers need to bracket the world and their individual biases or prejudices to reach the essence of the phenomenon being studied. In highlighting the analysis of the texts of the participants' lived experiences, I revealed what was said in its authentic meanings to minimize bias of interpretation. Specifically, the prejudices and assumptions of some researchers are not bracketed or set aside but are embedded and essential in interpretation (Laverty, 2003). Therefore, the lessons learned helped me better understand ethical problems and avoid biased information when working with older people. I recognize the importance of careful, fair data interpretation and that my professional background may be biased. The phenomenological theory is that only those who experience this phenomenon can convey their experiences to the outside world (Parahoo, 2014). As a phenomenological researcher, I set aside specific theories, hypotheses, inherent knowledge, and assumptions that differ from what we might see in a study about MCI among seniors (Creswell, 2013). van Manen (1997/2014) reminds us that researchers must recognize their previous background, experience, knowledge, beliefs, and influence in data collection, analysis, and interpretation.

Addressing cultural diversity

The analysis of older migrants’ stories is complex, involving the interpretation of language and understanding cultural implications. Some older migrants were bilingual or spoke many languages but had conversational English, which meant that interpreting transcripts often required further interpretation. In addition to this complexity, it is essential to acknowledge that participants with memory problems may have issues expressing themselves. MCI may affect cognition regarding executive functions, attention, language, memory, and visuospatial skills (Petersen et al., 2014). This problem applies to older migrants with reduced cognition, which was evident in some interviews. The data analysis was affected because of the clarity and legibility of the verbatim transcripts. On this issue, Hale (2014) suggests that it may be difficult for researchers and interpreters from distinct cultural backgrounds to convey a message accurately because of intercultural differences. To respond to cultural bias, I read and interpreted the data to better understand cultural issues and consulted with cultural advisors for guidance on specific cultural matters unfamiliar to me (Curtis et al., 2019).

Verification of data

After taking cultural issues into account, the next step was to verify that all data made sense and whether further iteration was needed. After analysing the transcripts, I contacted the participants again; I sent them back their transcripts; although most did not request a copy, I met with the two participants who sought clarity (Maya and Charles). Maya was delighted with her transcript and later emailed: “Many thanks, Ray; this is exactly what I want to tell my friends. Can I share it with others?” I consented to this request and again thanked her for her contribution. Charles was pleased with the content of his transcript, and he did not seek any changes. None of the other participants asked to see me or change any part of their stories.

Data analysis framework

The participants’ stories bring a unique sense of interpretation of their experiences. Crowther et al. (2016) illustrate that the purpose of analysing data is to reveal “which lies in, between and beyond the words while staying close to the phenomenon of interest” (p.4). In my analysis, I explored different data analysis models to better capture the life experience of the phenomenon of MCI. One that struck me most was the Antecedent Behaviour Consequence (ABC) model. The ABC model can help people study the triggers behind an experience, consider behaviours that contributed to the change, and understand the impact on negative or maladaptive patterns (Seligman, 2011).

In general, this model can be adapted to better understand what happened before someone had MCI, the behaviours that influenced them and the consequences of living with this condition. Albert Ellis (1956), quoted by Seligman (2011), created the ABC model to better understand responses to adverse situations. The ABC Model is a relatively simple tool to give an idea of behaviours that might otherwise be confusing to understand. One can assess the behaviour and then try to change it and create a hypothesis about why the issue has occurred and how to manage it. Antecedent (A) stands for a topic or aspect of a negative problem carrying an emotional response. Behaviour (B) involves belief, conduct, or explanation of why or how the situation occurs, and Consequence (C) suggests the resulting assumptions, feelings, and behaviours (Dryden et al., 2008). I have adopted a related interpretation of Ellis’s model to Seligman’s work on “Learned Optimism” in the data analysis, which resonates better with my methodology. From a phenomenological point of view, Seligman’s (2011) ABC model is contrasted with Heidegger’s (1962/2008) philosophy. In “Being and Time”, Heidegger advances the idea that if people want to understand a natural human experience, they need to understand the consequences.

In this study, an Antecedent is the effect of a specific, uncomfortable situation of developing MCI. For example, a person is thrown into this distressing situation related to family trauma, complications in a relationship, work, or physical and psychological health complications. The Antecedent is seen through the direct experience of human understanding, which Heidegger refers to as “events of nature that break in on us and destroy us” (p. 147). Data analysis shows that the severity of MCI is reflected in the central authenticity and awareness of its roots in dasein. This study shows the dasein of anxiety in participants' stories when they are thrown into stressful events or adversity of being forgetful.

Behaviour denotes response, and the person's belief is affected by the MCI. It conveys the message that being forgetful in daily life is common. Similarly, the Behavioural statement highlights the underlying perception of being thrown into distressing situations. Heidegger clarifies existential perception as "the behaviour of all human beings is "full of care" and guided by his statement of something" (p. 192). In this study, references are made to participants connecting to others as a common strategy. They interact with family and friends, connect spiritually, and engage in mentally stimulating activities.

The Consequence is about people's responses to and explains how participants understand memory problems and coping mechanisms. Consequences are related to "knowing", which relates to the precursor of the antecedent and behaviours, implying an explanation of multiple narratives with collective and recurring notions (Clandinin & Connelly, 2000). In this study, the Consequence is that participants know how to make common sense of MCI and show how they engage in many activities to circumvent their memory problems.

Phenomenology is a repetitive process, and the ABC model helps by repeatedly looking at the past and delving deeper into how a phenomenon will be experienced in the future, which is crucial to this research into the phenomenon of MCI (Laverty, 2003). Data analysis requires a thorough study of this process, which affects the qualitative data collection, interpretation, and reporting, as they are different but often linked (Creswell, 2013). It is also equally important that a phenomenological story is accurate and understandable, and that the reader can make sense of it.

Data analysis steps

There is no singularly appropriate way to undertake qualitative data analysis. However, there is a consensus that it is an ongoing, iterative process that begins with the preliminary collection and continues to the final analysis stage (Bradley et al., 2007). I spent over a year reading all the transcripts, dwelling on data, taking notes of emerging notions, and adding them to my analysis, as van Manen (2014) suggested. Participants' stories were analysed to create concepts and sub-notions based on van Manen and Heidegger (1962/2008). I found Annals' (1996) and van Manen's (2014) frameworks helpful in analysing the data. Annals proposes several phenomenology-specific criteria, such as an understandable and noticeable process and research product, a valuable survey, and an appropriate research approach.

First, I evaluated whether the study is comprehensible and appreciable, as shown in the methodology, which is straightforward to understand. I sought to capture fundamental notions that engage with the phenomenon of MCI. These ideas were then grouped and further developed by reading and rereading the data. Hermeneutic data patterns emerge that show possible hidden information (van Manen, 2014).

The second step is ensuring the study is beneficial for dissemination to stakeholders in older people’s services. Phenomenology is essential here because it offers a uniqueness of the participants’ lived experiences. The dissemination of phenomenological data emphasizes the concept of beliefs, feelings, and experiences, which is a unique way to support the findings of this study (Neubauer et al., 2019). Data analysis and interpretation show what “lies between and beyond words while staying close to the phenomenon of interest” (Crowther et al., 2016, p. 4). The findings point to the real-life experiences of older migrants with MCI in the Aotearoa New Zealand context.

Another step is to ensure that the research approach is consistent with the research question. I engaged in the data by familiarising myself with the topic of MCI to see what was revealed in the participants’ stories. I interpreted the connotations associated with MCI through an interpretative, hermeneutic process (van Manen, 2014). This process involves repeatedly reading the participants’ transcripts to capture and reveal relevant data on the phenomenon (van Manen, 2014). Interpreting phenomenological data is an inductive and iterative process of analysis (Wright-St Clair, 2015). In this method, hermeneutic phenomenology has helped me explore and understand everyday experiences without prior knowledge or personal insight into these experiences. Hermeneutics is an appropriate way to know how older migrants experience MCI daily.

In the data analysis phase, I examined every single transcription for common notions that appeared more often in the transcript and emphasized them to shape the findings chapters. Reading and rereading were an active, regular process in building trust in the data and familiarity with the concepts. I identified the participants' language patterns and words and the meanings associated with their spoken words. I found several distinct notions in analysing the data but needed more specificity in finding the hermeneutic sense. Support from my supervisors was helpful, as it guided me to form a “book of stories” for each participant. The book of stories proved useful in interpreting the data and developing chapters.

The subsequent data analysis phase moved concepts and sub-notions to the findings chapter. I explored phenomenological ideas different from the original approach but with many similarities. The notions centred on subjective knowledge, understanding, what MCI means and how it affects the participants. As I became more aware of the hermeneutic method, I realized each notion was influential in the analysis. However, the difficulty was dividing them into various categories and main chapters. The concepts were developed into four findings: being thrown into distressing events, being connected with others, forgetting every day, and knowing how to make sense of MCI.

Rigour and trustworthiness

Rigour is an essential methodological factor in any research. According to Koch (1996), a qualitative study aims to create a method and data collection report that can stand independently so that other researchers with the same data can draw their own interpretations or conclusions. Data interpretation depends on the researcher as they bring their unique background, professional identity and life experience to the findings (Creswell, 2013). All research studies require validity and credibility to determine rigour, reflecting the research method's trustworthiness (Parahoo, 2014). This issue is essential to qualitative research based on how the data align with universal laws, fairness, truth, and facts (Robinson, 2000). I established rigour in this study based on reliability, validity, credibility, transferability, reflexivity, and conformability for qualitative research (Prion & Adamson, 2014).

A phenomenological study must show methodological congruence to ensure that a data analysis process is thorough, valid, and credible (Robinson, 2000). To provide meaningful findings from lived experiences, I followed a hermeneutic data analysis principle to establish rigour by combining the phenomenological analysis methods of Heidegger (1962/2008) and van Manen (2014). This process helped bring the credibility of qualitative data into coherent stories to foster an understanding of relationships with distinct categories of notions.

Transferability is another essential consideration in the study. Transferability alludes to the effectiveness and relevance of the findings (Prion & Adamson, 2014). Though not explicitly related to the phenomenological principles, the clarity of findings is also essential. Transferability is whether the results are sound and if the study adds new knowledge to what is already known (Sundler et al., 2019). Transferability moves from aspects of wisdom to the entire experience, back and forth, to increase the depth of interaction and understanding of texts (Annells, 1996; Laverty, 2003). The results must be understandable, transferable to other studies, and relevant to a context broader than the original study. Specifically, the relevance, usefulness and meaning of the research results are vital components of the transferability of this study. Researchers often show that their findings stem from participants' experiences rather than their predispositions (Shenton, 2004). On the other hand, a hermeneutic concept defines the phenomenal interpretation of participants' stories. I have consistently ensured transferability; participants' stories are understandable, and their words are quoted as stated and interpreted by the researcher.

Another main factor in ensuring rigour is reflexivity. Once the data is coded, reflexivity involves examining one's judgments, practices, and belief systems (Prion & Adamson, 2014). Reflexivity identifies how personal beliefs may have affected the study (Sundler et al., 2019). I linked this factor to the methodological principles described earlier by the reflective attitude and questioned my understanding of this research. I ensured that I maintained reflexivity in both process and mindset. On this issue, Sundler et al. (2019) suggest that qualitative researchers are actively involved in this process and need to think about the state of data, which may differ from their prior understanding; the researcher should question the findings rather than take them for granted. Comparison between van Manen's phenomenological lens (2014), the researcher's point of view and the interpretation of the subject by research participants are essential criteria for establishing reflexivity. Results must be illustrated by the original data (participants' quotes) to show how they have been derived and not based purely on the researcher's interpretation. My supervisors closely tracked data interpretations to ensure they aligned with the research question and applied the correct methodology. The reader can understand the actual perspective of the results free from the influence of judgment or belief (Sundlar et al., 2019).

Lastly, confirmability is another factor in rigour, which is how researchers agree or confirm findings (Elo et al., 2014). Confirmability of the findings is objective and stresses the meaningfulness of the results achieved by reducing the distance between the researcher and the participant (Gethin, 2009). Confirmability is not dependent on participant involvement but is helpful because it emphasizes the meaning of participant life experiences. Confirmability is to maintain my neutrality as a researcher in interpreting the results, ensuring objective and subjective data are free of (inherent) bias (Nyirenda et al., 2020).

The research findings were presented at local and international gerontology conferences for added reliability (Appendix L). All transcripts were sent to the participant for reading and commenting. Dissemination to the memory team and gerontology services in Auckland (Te Whatu Ora) and presentations for local NGOs and community services are planned. This process added methodological rigour, openness, and reliability to the investigation. Feedback obtained during the dissemination of these research outputs reinforced the validity and conformability of the inquiry (Prion & Adamson, 2014).

Summary

This chapter has outlined the research design of the study. This study's research method and philosophical basis were illustrated, and I identified my epistemological and philosophical approach to the subject. I unveiled the basic concepts of understanding the lived experience of MCI among older migrants. Hermeneutic phenomenology through van Manen’s (2014) and Heidegger’s (1962/2008) lens was highlighted, and their philosophy shaped my understanding of older migrants experiencing MCI. My mental health experience shaped my knowledge of MCI in older migrants. The methods outlined ethical approval processes, cultural considerations, participant recruitment, and data collection. I explained the steps in preparing for the interviews, adding professional bias and dealing with cultural/ethical issues. I outlined how data was verified and what data interpretation model I used before describing how the four main results turned into notions.

Chapter Four: Being Thrown into Distressing Events

Introduction to the findings

The previous three chapters presented the background, literature review and methodology. In the following four chapters, I present the results of all the data collected and analysed during interviews with 15 participants. The findings were informed by phenomenology and based on the interpretation of qualitative design. Notions from the participants' 'book of stories' interpret the voices of older migrants and their lived experiences on the issue of MCI. These stories of everyday experiences reveal stressful moments in confronting the challenges of memory loss. The findings indicate notions that play a significant role in their lives and how others can learn from these experiences.

Phenomenology aims to "discover in a certain way" what is "concealed" or "hidden" in the everyday experience of that individual (Heidegger, 1962/2008, p. 19). Being thrown into distressing events emphasizes the concept of "being thrown" or being exposed to uncomfortable situations (Heidegger, 1962/2008). The narratives explore older migrants' stressful experiences and the challenge of living with MCI. Heidegger's notion of thrownness captures dasein to show how older migrants are affected by it. The thrownness is a foremost concept for MCI because memory problems are the trigger.

Older migrants' stories are uncovered in the following four chapters regarding their experience of MCI. The first finding chapter stresses how family trauma, complications of marriage, retirement problems, physical health problems, social isolation and acculturation affect their memory. Chapter Five highlights older migrants connecting with family and other people in their community. It reveals their stories of socializing, praying, and interacting with diverse community organisations. The subsequent chapter of findings emphasizes the participants' experience of forgetting daily events, tasks, and notable events. This experience reveals their cultural understanding and how memory problems lead to embarrassment or frustration. The last chapter shows how older migrants make sense of their memory problems and identify self-management strategies to prevent memory from worsening.

Harrowing family experience

The first notion stresses that being thrown into distressing family events or circumstances can contribute to psychological problems. Stress could affect how memories are brought into being. Creating short-term memories is challenging when someone is stressed, and learning new skills is harder (Chu et al., 2022). Phenomenologically, it is about participants who are thrown into an existence which has a negative impact on their psychological health and memory. Here, Heidegger (1962/2008) points to human beings thrown into traumatic circumstances, which is reflected in the aspect of "Being-in-the-world".

In this study, participants’ stories show a sense of heartbreak because of stressful events affecting their cognitive function. Such events cause psychological health problems and could adversely affect memory (Rosin et al., 2020). Participants described first-hand experiences of terrifying, traumatic, and harrowing circumstances.

The first story illustrates Charles, a retired 67-year-old South African migrant who previously worked as a taxi driver and real estate agent. He shares how he suffered acute stress from family problems and health complications. Consequently, this has affected his memory:

> *When I arrived from South Africa, the oldest son had completed his studies and began working as a commercial pilot, and the younger one was studying. My wife was a nurse in a Cath lab. I came here to retire but ended up buying myself a taxi. Then the oldest boy decided, ‘Nah, I will pick up a partner.’ Now to us, it is conservative. Older people believe that you either get married or do not. What I do not know is that we live together.*
>
> *Being a young man, he had decided, and I do not know whether it was under the influence of the girl or something: ‘no, I am going to go’; Well, you go away, mate. Later, he wanted his share, so we got rid of our rental homes and paid him a share. We went through lots of arguments with lawyers and paid him out. So that turned out to be stressful. To me, it was traumatic. With the younger ones, 13 or 14, you can still reprimand him, but when a 25-year-old tells you, I’m out at this point, mate, cheers. This is it. You know, you do not have a say in the case, and I have been getting forgetful ever since.*

Charles recounts the onset of memory problems following the stress of his son leaving the family home, recalling it as a traumatic event when his son tells him, “Nah, I will take a partner.” When his son physically left, Charles’ trauma experience changed his condition forever. He describes being of a “conservative” background where “older people” of his generation rarely accept a de facto relationship. Charles adhered to this view, and despite living in Aotearoa New Zealand, his cultural belief that unmarried people do not live together was challenged, causing negative feelings towards his son. Charles finally paid out his son’s inheritance to sever their relationship. Yet, the stress continued well after his son had left the family home, and Charles shows being thrown into a layer of tension or anxiety based on many legal squabbles over the son’s share of the family’s accumulated wealth, to which he reluctantly complied. This event shows a sense of Charles’ disempowerment, weakness, and inability to do anything about his son’s behaviour, a mixture of emotions, anger, loss, and shock. He was thrown into a traumatic event, not of his own volition, which affected his cognition.

Charles continues his story and discerns a link between expecting the unexpected in a traumatic family feud affecting his memory:

> *Well, my trauma is just in the sense of heartbreak. You feel traumatized because you do not expect it to happen. You think your family is well-adjusted and well-protected, and nothing can go wrong. Suddenly boom! Out of the blue, your son comes home and says, I got somebody pregnant and decided I will walk away now. You know this boy, grown-up from baby to 25 now, always listened to me, followed my advice, and did things together, yet I am telling him this is not good for you. Yet he is saying to me square face to face. I am out of here. The traumatic*

> *experience was a shock, and you cannot resolve it. My trauma memory problems come from that terrible experience; it hurts. Since then, I have had memory slips.*

Charles' son's departure triggered deep trauma, leading to Charles' persistent grief. He describes this traumatic incident as hurtful because his son's response was unexpected. Charles explains how his family admirably "adapted" and was "well-protected", forming a belief that nothing could go wrong because of this protective mode. He feels shocked by this incident, suggesting how his son always "listened" to his "advice", and they "did things together". Despite disagreeing with his son's plan, he was disappointed and shocked after the confrontation. From Charles' point of view, his son did not meet his expectations. This traumatic experience contributed to his memory slip-ups, perhaps because he could not solve the situation and, as a result, gradually became psychologically unwell.

Gemma is a 72-year-old retired teacher from Brunei whose memory problems surfaced after several family stresses:

> *My ex-husband was a drunk and wasted all our money, which disturbed my memory. So, I am now separated; he is now in Kerala, India. Before, I just got blank sometimes when I was stressed about him. He was coming home in the morning drunk, and I got used to getting out of that situation, but it gave me much stress. When I become concerned, I feel terrible. Now I have memory problems affecting me daily.*

Gemma tells of her memory initially being affected by her husband's drinking habits, which later affected her marriage. She reveals that her ex-husband spent their savings on alcohol, which seems to have caused much stress in her life. Later, the relationship fell apart. Gemma describes feeling "blank" when she is stressed. Despite getting used to her ex-husband's drinking, she describes feeling "terrible" and reveals her memory worsened because of his behaviour. Gemma describes further unease in her life after stressful situations involving her two daughters:

> *The eldest daughter was educated in the United Kingdom with an MBA. I got a very nice salary in Botswana, and I was wealthy there and helped her. I hinted at her taking prominent roles. When she got here and sadly, she left for Dunedin. She is married and has two children. I live with the other daughter now. When I was concerned about her, I just switched off. I am worried because I do not like her partner much. On Fridays, he usually comes home; on Thursday evening, I start getting palpitations. She loves to be with him but does not love him. He does not like me, and whenever he gets home, he does not speak but waves at me or simply ignore me. I am nothing like that because I do not come from that sort of family. My daughter and I are cheerful and bubbly; we are like a single family. So, someone told me to ignore him. But I am a person and feel uncomfortable about being with a stranger. So, this affects my memory.*

Gemma tells of her daughters' excellent upbringing and education and how they were propelled into high-profile jobs. She describes feeling anxious after one of them moved to Dunedin, hinting at her sorrow in the wake of her departure. While Gemma does not convey any significant stressors here, there may be some hidden stress when her daughter leaves, partially explaining her 'sadness'. There is the possible concealment of missing her daughter and grandchildren. Gemma conveys stressful situations regarding her other daughter. Gemma hints at distaste for her daughter's partner, who visits occasionally. She describes "imaginary palpitations" and seems "uneasy" about him. Though Gemma perceives her daughter as enjoying his company, there appears to be some anxiety because he ignores Gemma. She describes herself as a "cheerful and bubbly" personality and cannot ignore him, as someone suggests she should. Gemma recounts that these stressful problems "affect[ed]" her memory, indicating the source of her current memory problems.

Worrying about retirement

Stress affects older migrants approaching, or already in retirement. Concerns expressed include finances, taking care of oneself, and health issues. Some participants describe being retired as bringing more stress which affects memory.

Audrey is a 78-year-old retired schoolteacher from India. She shares a story highlighting the stress she experienced since her retirement and the impact on her memory:

> *This stress must have started at least after I retired at 60. It was okay for a few years; then, I worried about things and got too confused, misplacing and forgetful. I have been experiencing memory problems before staying with my daughter [Auckland]. My son-in-law works locally, my grandson does his research at the university, and my granddaughter lives in Melbourne, auditing or risk management. I have been forgetful lately, which was not like that before. I knew exactly where things were in the house. Now I am a bit confused, and I try to keep things in a safe place, but then I forget that safe place sometimes, and I must look all over.*

Audrey begins her story by explaining that she has lived with her extended family for several years. Her memory has worsened since she retired, and she recalls how it was perfect before migrating. She recounts her difficulties living in Aotearoa New Zealand, and how her memory deteriorated. Audrey describes keeping all her items safe, but she forgets where that "safe place" is. Such confusion may be worrisome for Audrey; as a result, she becomes stressed, and thus her story links to memory problems.

Experiencing stress after retirement and its contribution to a decline in memory is also an issue for Gemma:

> *About eight years ago, things got worse. Nothing awful happened before that, and I was okay. In 2006, I taught at a technical college in Botswana. My problem began after I stopped working, and my brain became lazy. I typically have solid willpower. However, now, it takes much energy to pay attention to something. I cannot concentrate for over 20 minutes. Then I switch off and dream.*

Gemma speaks of the onset of her memory deterioration after retiring as a teacher. Since then, she tells of her brain getting "lazy", suggesting mental fatigue, slowness, or not paying attention. She describes having strong "willpower" but now requires much energy to stay focused. From previously having an excellent memory, she now cannot focus for long and seems to “switch off” and “dream” during the day. Her switching off appears to slow down mentally because of her low concentration level.

Acculturating

Acculturation is a process of psychological and socio-cultural change resulting from the influence of migration (Schwartz et al., 2010). Acculturation can significantly impact the mental health and wellbeing of migrants (Choy et al., 2021). In contrast, integration may have the opposite effect because if people are more socially connected, they are considered happier and less stressed (Choy et al., 2021). The link between acculturation and psychological health is complex and may differ from one culture to another. Furthermore, the trauma of older migrants moving to an unfamiliar country can often translate into social isolation, sadness, or missing family and friends and what they once enjoyed in their home country. Key sources contributing to acculturation stress and worsening cognitive problems may include low education, skills, ability to learn a new language, and financial difficulties (Choy et al., 2021). Such stress is often linked to memory problems in ageing migrants (Gruebner et al., 2017).

Acculturation seems to have affected Catherine, a 72-year-old Chinese migrant who explains difficulties adapting to life in Aotearoa New Zealand. She recounts cherishing her earlier life in China and describes the challenges she now experiences. She struggles with memory problems that make her feel lonely:

> *Apart from isolation, life here is no better than in China. I compare it to China because, in China, where I came from, a big city, there are always many people. Suddenly, I came here, and it was a quiet country. It is something I need to adjust to right here. I am not used to the calm. This affects my memory; although I can still travel by bus anywhere, people say nothing about my memory problems. This is common and not a big problem; it is just part of getting old. I just have a memory problem when I go out and forget the keys, or I must remind myself not to rush out to be less forgetful.*

Comparing her earlier life in densely populated China with her new country, Catherine speaks of feeling isolated, which she experienced when migrating to a “quiet country”. She says of the need to get used to the “calmness” of her new country. “Adjusting” to a different culture appears to have affected her coping mechanism and memory but not interfered with her daily life; she uses public transport without help. She reflects that no one mentions her memory problems, which she attributes to “getting old” and something she needs “to adjust to”. Catherine recounts how her “memory problems” affected her daily activities and perhaps came with acculturation. Her coping strategy is “not to rush out”, which helps with her memory problem.

Maya is a 68-year-old retiree from Hong Kong and the group leader of a community organisation in Auckland. Her story is about the stress of migrating to Aotearoa New Zealand:

> *After moving to New Zealand, I first noticed I could not find the items I use every day. I came here without work from Hong Kong, so there was some stress. I must adapt to everything here, and then there was some pressure. I did not know if I*

> *could stay here or go back to Hong Kong. Yes, it is the pressure. And then again, I was not entirely happy because I had to pay for everything every month, but now I have used all my savings. So that made me worried, and it affected my memory. I do not believe depression and loss of memory are the same. We have a couple of pretty sad members in the community organisation. Because they have moved here and are unaccustomed to their lives at home, their children are not kind to them, or they have lost their partners. However, having our group activities and singing and dancing brightens their lives when joining us.*

Maya describes her life in Hong Kong before retiring to Aotearoa New Zealand, and the "pressure" she feels adapting to her new life. Maya recalls the fear of not knowing if she might stay or "go back to Hong Kong". Acculturation adds to not being "happy", feeling "pressure[d]", and experiencing financial worries. She notices difficulty finding specific things at home, which she attributes to memory problems. Maya mentions "depression and loss of memory" and tries to link both circumstances with the adjustment of her friends in this country. She reports weekly interactions with the community group and believes in the importance of bringing together people with the same emotional problems to help them adjust to Aotearoa New Zealand. Maya depicts some members of her association feeling "sad" and assumes it is about acculturation problems and family dynamics. She suggests getting the older migrants together for group activities to help reduce both emotional and psychological issues.

Driving incidents

Not being able to drive, or causing driving accidents, is a common problem for many older people, especially those with cognitive issues. Driving incidents make older migrants anxious regarding lack of focus, concentration, vision or memory problems.

Sam, a 60-year-old Samoan migrant, has been a bus driver since he came to Aotearoa New Zealand, a decade ago. Sam describes a significant incident while driving recently and links this to memory problems:

> *It all started one day when I was driving my bus and, on the road, I stopped and thought, oh, am I still at home? But you are on the road, and I remember I am still driving. So, this is the first time I recall losing my memory. I was somewhere else, and I lost my mind while driving. So, I slowed down, put the bus on the side of the road, and said, "Wake up my head". Then again, I said, what's going on? A short time later, I did the work correctly and drove off. If something happened, I could kill myself or everyone on the bus, which would have been a significant loss.*

Sam tells of a moment of "losing [his] memory" when driving his bus. He recounts his fears that he might have "kill [ed himself] or everyone on the bus" because of his "memory". This was the first time Sam noted such a problem, thinking that he was somewhere else when his focus should have been on the road. In trying to get a sense of "[losing his] mind," he tells his brain to "wake up" and questions what is happening. Sam seems to have lost concentration while driving; poor concentration, thinking, and judgment are common characteristics of MCI (Hsiao et al., 2016).

Joan, a 70-year-old Korean migrant, describes the deterioration of memory problems. Her story depicts her mind ‘wandering’ while driving, which leads to her inability to drive:

> *My mind sometimes wanders around at night. I could not drive; it would be dangerous, so I stayed home. I simply cannot cope. I cannot drive now because my eyesight is not good. After many years without proper sleep, my brain function has worsened. I think things have been getting worse slowly. Sometimes I only get two or three hours of sleep, and then I cannot focus the next day. My concentration is not perfect, so I cannot drive. Everybody tells me you are too young to have a memory problem. However, it is indeed too dangerous to drive.*

For Joan, insufficient sleep means she cannot correctly drive or focus the following day. She understands the consequences of her mind wandering at night; the subsequent lack of focus becomes why she “cannot drive” anymore. Joan’s anxiety about living with memory problems is not helped by being told she is “too young” to be experiencing them. She appears much younger than her years; perhaps, her friend mentions that she is “too young” to have such problems. While not an outwardly apparent factor in Joan’s case, memory loss is a significant problem for her, albeit people tell her she is still young.

Gemma stopped driving after being involved in a road incident. She attributes this to have been caused by memory problems:

> *Three years ago, I was picking up my grandchildren from school. People honked at me because I stopped on the pavement near the school. Then a police officer got out of his car toward me. He was dressed in plain clothes, so I was afraid to put the window down. He said, no, I am a police officer, off duty, and you do not have to feel scared. Police questioned me if it was my first time going on the pavement. I said no a few times. He said you need to practice more, and when you feel mentally tired, do not drive. He was a friendly police officer; he did not give me a ticket and took me home. He did not ask me not to move. But afterwards, my daughter told me to stop driving. So, I stopped, though I could still do it. But for safety reasons on the road, I should not drive because of my health problems.*

Gemma recounts this incident when she drove onto the pavement while picking up her grandchildren from school. Other drivers raised concerns, and an off-duty police officer advised her not to drive when feeling “mentally tired”. Following her daughter’s advice, she agrees to “stop driving”. Gemma confirms this is for her health and “safety reasons on the road”. Being thrown in this incident shows the far-reaching consequences of Gemma’s memory problems.

Susan is a 79-year-old Chinese migrant who reports a significant shift in her memory following a car crash when she was hurt. She attributes this incident to worsening memory problems:

> *About five years ago, I had an accident, a car crash, and I was injured. I had much stress due to this, which affected my memory. So, I feel that my memory has been getting worse since then. For example, I want to learn English but cannot understand it because I cannot remember well.*

Susan describes injuring herself in a car crash. Since that incident, she tells of experiencing memory problems. She describes her “memory […] getting worse”, which caused her “much stress”. Learning English is stressful for the same reason. Her problems are highlighted by her learning and focusing difficulties; the driving incident seems to have exacerbated her cognition.

Distressing health conditions

Feeling distressed about health problems was a common factor for some participants. Participants identified health and age-related problems, including sleep deprivation, hearing loss, shingles, cardiovascular problems and depression.

Joan was a pharmacist in Korea. She has a good grasp of her health issues and cites sleep deprivation as contributing to her current memory problems:

> *I am a pharmacist and self-diagnosed myself with sleep problems. I think I have had sleep problems for a long time. Since the age of 50, my sleep has not been perfect. All I had was a problem with broken sleep. I have tried everything, including herbals. It has been much worse recently, and I could not sleep very well for two or three years. After that, I need to take a sleeping pill. Even though I take half the dosage of 50, I get only four or five hours of sleep. Afterwards, I woke up, had a slight headache, and the last one or two hours. After that, things are all right. I do not want to keep taking sleeping tablets, but I cannot. I cannot sleep without it, and now my memory is affected.*

Joan draws on her professional background to make sense of her memory problems and self-diagnoses her sleep difficulties as the leading cause of her problems. Joan’s story connects her long-standing insomnia with her memory problems. She confesses to self-medicate with “herbals” and “sleeping tablets”, perhaps based on her professional knowledge, despite these products lacking efficacy. She appears to have been thrown into health complications because of lack of sleep, contributing to her memory problems.

Eileen is a 79-year-old migrant from China. She tells of how her physical health problems are caused by memory problems:

> *I have a few health problems, like high blood pressure and hearing problems. I worry mostly about memory problems and hearing. My hearing makes life less enjoyable. Yes, it is just like watching TV; I enjoy it, but I cannot quite hear without my hearing aid. The doctor also confirms that I have had a poor memory since then.*

Eileen reveals that her doctor said her “memory” problem stems from physical health issues. Eileen has anxiety about hearing loss and hypertension, which makes her life awkward; for example, she cannot properly hear TV programmes. Perhaps suggesting physical health problems have affected her memory, reiterating the connection between memory loss and moderate to severe hearing loss.

Lynette is a 76-year-old South Korean migrant. She shares how the effect of shingles has affected her and fears this has contributed to her memory problems:

> *Last February, I had shingles over my shoulder and neck. Often, I got a headache and quite a heavy head on the right side of the brain. I feel like I cannot think*

> *straight and understand what people say. Afterwards, my forgetfulness worsened. I believe shingles have affected the quality of my memory. So, the shingle[s] affects my mental state, which makes me forgetful. It has taken me a long time to understand that shingles could affect my brain, and I am concerned. Usually, it occurs in conversations; I often forget things. I could hear what people said but could not understand them. I had a clear recollection of the past, but lately, things have changed.*

Lynette begins this narrative of her worsening memory by describing "shingles" on her shoulder and neck. She explains the pain as a "headache" and a "heavy head" since the shingles began. In doing so, Lynette conveys her understanding that "shingles affect" her "brain", making her "forgetful". Lynette explains why she cannot think straight or understand what people say, and it is perhaps comforting to see shingles as the cause. It is not her but the shingles that "affected the quality of [her] memory". But when she describes her "forgetfulness has been worsening", she seems to think her memory has been affected by these shingles.

Maya moved to Aotearoa New Zealand, about a decade ago and lived with her husband and daughter. Maya's story is about experiencing physical health problems affecting her memory:

> *I am pre-diabetic now; I have high cholesterol and high blood pressure. I also have a knee problem. I try to get more exercise for my knee, and then I take some painkillers, which seem fine. But it is my memory. Yeah, things get worse. Of course, I am pretty optimistic but old, so I should take it. Of course, I wish I could stay as healthy as before, but that is impossible because now I am retired. Life is simple, and I do not struggle for jobs or money. I no longer have that sort of stress, but you accept that there may be more physical health and mental problems.*

Maya begins her story by describing several medical problems and experiencing worsening memory difficulties but feels optimistic about getting old; she is realistic about accepting the ageing process. Maya tells of her desire to stay healthy and implies that she had good physical health before she retired; this means a comfortable life without "struggle[ing] for jobs or money". She seems optimistic about her health problems and accepts that life comes with distressing "health problems".

Mary is a 78-year-old Chinese migrant with a history of depression. Though her mental health has improved, she now notices memory problems affecting her:

> *I live with my son and daughter-in-law, but they are busy with their own lives. My husband died seven years ago, and then I was sad, so I went into depression. I saw a doctor and was on treatment for about four years. And right now, I am feeling all right. We have been together for so long, and it was difficult for me to bear it. I was distraught, and then afterwards, I became ill. Later, my memory problem occurred; it did not occur all the time, but occasionally. Some youngsters even have this kind of memory problem.*

Mary describes being a widow and tells of the difficulty enduring her loss leads to depression. Despite recovering from it, Mary then developed "memory problems". She mentions "youngsters" who suffer from "memory problems" too, perhaps attempting to justify memory problems as perfectly usual at all ages. In interpretation, Mary seems to think memory problems are not purely an issue of ageing and downplays them as less severe than depression.

Anne, an 83-year-old Korean migrant, links ageing to her memory problems:

> *I am becoming more forgetful because of ageing every year. Sometimes when someone asks me to do something, I forget minor things. Last time my daughter reminded me to use a tissue when I had a runny nose. I know I need to throw it in the bin, but I ignore it and forget. Suppose I concentrate on something or follow instructions. Otherwise, I am going to forget things easily. Previously, I was pretty intelligent, studying, working hard and had no apparent memory problem. Since last year, I have been getting more forgetful, but there was no severe incident except when I go shopping. Young or middle-aged people say I forget before it happens because of age.*

Anne's story is about feeling anxious due to her memory loss, which she links to the ageing process. Anne describes forgetting the routine of using tissues to blow her nose and get rid of them. Though she downplays her memory problem by saying her forgetfulness is only minor, she admits to remembering things when she remains more focused. Anne recalls previously being quite "intelligent, studying [and] working hard". However, she is now markedly more forgetful, which causes her distress.

In another of Charles' stories, he equates his poor memory with the beginning of physical ageing:

> *Small things I slip up; I would have put it on ageing personally. Am I going mad? I do not know, but I think it's my age, and I am usually not forgetful. I am wrong with names, which have been that way for a long time. I take a moment to remember a word. It happens if I do not have to remember it. I know you now and your name. We have a common thing we are doing here. But when you leave, your name will slip my mind. Whether that is cognition or just a particular problem, I feel disappointed. Oh goodness, I think it has been two to three years now that I have been forgetful. That is what I call it, right? Or is there another medical term? It is a trivial thing.*
>
> *For example, one day, I had to do the lawn with an electric mower, and you know, I had to move the cable. However, you become engrossed in cutting and forget. You go over it and trip the power. I do not know whether you put it down to forgetfulness or simply stupidity. I get upset and reprimand myself for being stupid and not thinking. I did not simply throw my hands in the air and walk away, but I finished the task. This was funny; I did one part, forgot another, and laughed.*

Charles downplays events when he is forgetful, pointing to memory "slip-ups" and "ageing". He hints that his forgetfulness is a form of "cognition" problem or simply being selective and ponders whether he is "going mad". He offers another rationale for being forgetful, wondering whether a thing is necessary to remember or if there are no connections, he will forget. Charles comments that he will forget my name when the interview is over because it will "slip [his] mind". There is a sense of frustration because of these "slip-up[s]". Charles' story provides a valuable instance of his forgetfulness, questioning whether being forgetful is a proper expression for his problem. Charles forgets what he describes as trivial things, such as moving the cables of his electric lawnmower, because he is so "engrossed" in the task. He questions whether his actions are due to “forgetfulness” or if he had been merely “stupid”. He then deduces being “upset” about his lack of concentration and reprimands himself, admitting it was trivial. Charles, instead, depicts this incident as another chapter in his memory problems. In interpretation, there appears to be a lack of insight into the seriousness of the incident because he perceives cutting electrical cables as “funny”.

Feeling isolated

Social isolation can be a painful experience for older people. For older migrants, being thrown into lonely situations means sadness, distress or separation from society. It may occur over a prolonged period of disconnection from family or friends and when surrounded by people. Some of the participants have a sense of feeling lonely, which is associated with their memory problems.

Susan attributes feeling isolated due to stress, which also affects her memory problems:

> *I live alone here, which gives me a little stress for my partner and me. Before we lived with my daughter and grandchildren, she later moved overseas. I must bear it like this, and we are right now alone. We have little to say, so we are lonely. We both have memory problems, so we do not hate each other but help and support each other because there is no one else to do it. For example, he reminds me, have you had your medicine on time or eaten anything?*

Susan tells of feeling “alone” since her family went abroad. She also discloses that she and her husband experiences “memory problems” and “stress”. She feels “lonely” even though they are living together. Her rationale is that they “have little to say” to each other because they both have “memory problems”. Susan’s memory problems seem to be related to social isolation and her daughter’s absence. When she says of having to “bear it like this”, it appears she sees no hope in her current situation. However, she finds comfort in her husband’s reminders that they support each other’s well-being. She says his memory is not as bad as hers because he reminds her to take her medication and eat or drink promptly because “there is no one else to do it”.

Another of Mary’s stories describes her memory problems for some time. She says her forgetfulness stems from being lonely, grieving, and having no friends since her arrival in Aotearoa New Zealand. Over time, her memory problems seem to have worsened:

> *When I first came to New Zealand, I was despondent and felt lonely following my husband’s death. It is probably because I did not have any other friends. Over time my loneliness affected my brain, although it is much better now because I go to the Chinese community association. Back home in China, because it has a very dense population, the government does not seem to do anything for people like me (with memory problems). The family needs to deal with their older family with memory problems. However, here it is different; the government is concerned about taking initiatives to help older people with memory problems.*

Mary mentions that older people with memory problems live better in Aotearoa New Zealand. She speaks of how more senior people in her densely populated hometown, where the government does little for “older people” with memory problems. She remembers feeling alone when she first arrived in this country. However, she expresses feeling “much better” after joining a Chinese community association. Mary refers to the improved mental wellbeing of older Chinese when they connect socially, an initiative to help reduce social isolation.

Audrey’s story conveys being alone following her husband’s death and feeling lonely again when she came to Aotearoa New Zealand. She seems to have developed memory problems since then:

> *After my husband’s death, I was alone at home. I lived near my son, who was living nearby with his family. But then he moved to Mumbai. So, I was lonely again and found it challenging to cope with my memory problem. I thought it would be better to come here with my daughter and see how things are. Then again when I arrived, very lonely here, particularly in the evenings. However, throughout the day, time passes quickly. There is something to do in the house. Fortunately, I have great neighbours, too; they always keep coming and going. However, they would go away one day, which is frightening because I would feel lonelier. And then I have been experiencing memory problems that make things worse.*

Audrey describes the aloneness after her husband’s death worsened after her son moved to another city, prompting her to migrate to Aotearoa New Zealand to be with her daughter. In her earlier story, she referred to memory problems after she retired. Audrey feels alone again, particularly in the evenings, which compounds her memory problems. For her, the day goes by quickly because she finds something to preoccupy herself in the house or connect with her neighbours. She worries about their leaving one day, making her lonely again. After reflection, it seems that Audrey, alone in India, has come to another solitary place to live. Although she finds comfort with her family and neighbours, she feels anxious that they might not be there anymore. Her story reinforces the adverse effects of social isolation, adding to stress and memory problems.

Reflection

Philosophically, the central concept of “being thrown into distressing events” is based on Heidegger’s (1962/2008) concept of “thrownness”, which is about a human being thrown into the world. The notion of “being thrown” into stressful situations is interpreted as being thrown into the world of an older migrant’s life and weighing its impact on their memory. Participants shared how they were exposed to adverse events over time, leading to psychological problems. By highlighting the importance of thrownness, participants have shown how adverse events affected their memory. The idea of being thrown into distressing situations, such as social isolation, health issues, and traumas, illustrates some of these stressors.

Thrownness is one of the three fundamental existential formations of dasein, an essential philosophical aspect of human beings (Heidegger, 1962/2008). The “mood tells us how things are going and shows that we are always “thrown” into a situation to which we must respond” (Harman, 2007, p. 68). By implying that the individual is “thrown”, Heidegger tries to catch the essence of something crucial about the mood of human beings. The connection between mood and thrownness is described by Ratcliffe (2002), suggesting that “in order to make sense of certain neurological conditions that traditional assumptions concerning the mind are constitutionally incapable of accommodating, something very like Heidegger’s account of “mood” and “emotion” needs to be adopted as an interpretive framework” (p. 27). In Ratcliffe’s view, “being thrown” shows that human beings are exposed to or affected by a particular situation. Their consciousness is uncovered or exposed. In this study, traumatic situations such as the anxiety of acculturation, health problems, grief, and ageing manifest in “thrownness”. A sense of lack of control is unearthed by being thrown into those instances and resulting in memory issues.

From another phenomenological perspective comes the term “Angst” [3]. Angst is translated as anxiety or human distress, forming part of the idea of dasein, being thrown into a stressful situation (Heidegger, 1962/2008). From this perspective, Heidegger (1962/2008) reveals that “we shall take the phenomenon of falling as our point of departure and distinguish anxiety from the kindred phenomenon of fear” (p. 227). Heidegger suggests that life events are natural, but anxiety is exceedingly difficult at times. Heidegger's definition of angst may not correspond to the existing clinical definition of anxiety but shows a deeper degree of anxiety that affects cognitive health. In understanding angst, broader notions about anxiety must be considered. Importantly, angst is inextricably linked to several key concepts associated with an ontological perspective of dasein and “Being in the world” of an individual with memory problems. In this study, stories reveal the angst of being with or without family, retirement, physical health problems, driving, acculturation and isolation, all of which may have contributed to or worsened memory problems.

Reflecting on participants’ stories, I encountered instances such as marital problems underlining the angst of “being with” a family. Not everyone enjoys a happy relationship. Gemma’s story shows heightened emotions, illustrating her complicated relationship with her ex-husband: “being with” will always influence “being with others”. A more comprehensive description of Heidegger’s (1962/2008) philosophy suggests that we cannot avoid being influenced by “being with” other people and “being in the world”. Heidegger posits that human existence is subjective and closely linked to the world itself. A meaningful experience in caring for one individual could bring anxiety to others. Frequently the relationship with “being with others” gives our existence meaning but does not necessarily have a positive outcome.

Another recurring notion in participants’ stories was retirement, ageing, and the unexpected effect on their memory. While retirement may be joyous for some, Audrey and Gemma's stories go beyond that. Both experienced angst and memory problems after retirement, showing that dasein is an influential part of the “being in the world” of retired people. Retirement appears to be existential stress on physical and mental wellbeing, although studies

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[3] Angst is another notion of Heidegger depicting the feeling of deep anxiety or fear.

report that retirement can reduce stress in men but increase it in women (Chen et al., 2020). Their stories explain being thrown into situations—meaningful but painful experiences that have played a vital role in their current circumstances and continue to affect their lives.

Looking back on the migration experience, several participants describe how they struggle with acculturating to an unfamiliar environment. Heidegger (1962/2008) highlights the relevance of mood, fear, and anger. Moving to a new country may affect anxiety and bring a heightened sense of loss and fear of the unfamiliar place. Participants portrayed angst and contributed stories about being thrown by physical health problems, ageing, grief, and social isolation. A possible hypothesis is that when people migrate from a busier, densely populated environment to a quieter and more insular one, they feel more alienated (Bhugra, 2004). Heidegger (1962/2008) asserts that "in a state of mind, Dasein is always bought before itself and has always found itself, not in the sense of coming across itself by perceiving itself, but in the sense of finding itself in the mood it has" (p. 316). When an individual settles in a new country, acculturation and alienation may contribute to strain, resulting in psychological problems (Bhugra, 2004). Catherine, Maya and Gemma's accounts are typical of being thrown into a stressful situation. "Being there" has contributed to "being thrown" into cognitive deterioration.

Summary

This chapter uncovered the theme of being thrown into a distressing event. Older migrants are thrown into stressful situations or experience adverse life involvements, leading to memory problems. Anecdotes shared by older migrants describe how their memory affects their daily lives; family traumas, post-retirement problems, acculturation stress, driving problems, health problems, and social isolation are typical examples. The primary notion of "being thrown" affects the memory of older migrants when exposed to stressful and traumatic events. From a philosophical perspective, the various dimensions of "thrownness" and "angst"—notions of Heidegger—are highlighted. In the next chapter, I will present participants' awareness of memory problems and how they connect with others in their daily lives.

Chapter Five: Being Connected with Others

The previous chapter revealed the features of older migrants being thrown into distressing events contributing to memory problems. The findings of this second chapter will be based on participants' stories of how they connect with others. This chapter mentions how they navigate such experiences and connect with family and friends to help improve their cognitive health.

A close, supportive, meaningful connection with others is good for one's wellbeing and cognitive health (Chen et al., 2020). I have already emphasized the familiar notion of being alone in the last chapter, and this chapter indicates a need for older migrants to be connected with others to alleviate the sense of social isolation. Heidegger's (1962/2008) idea of "being connected with the world" is a strategy to prevent social isolation and engage in mentally stimulating activities, which also helps to enhance memory (p. 44). Sub-concepts show how participants connect with families and friends in community organisations, places of worship and day centres. Participants' stories demonstrate that being spiritually connected and engaging in diversional activities helps keep their minds supple.

Interacting with other seniors

The interaction of participants with others is the essence of connecting with family and friends. Some participants describe attending cultural organisations as being with people of the same cultural background and as a strategy to socialise and improve their cognition. Cultural centres are vibrant community organisations that offer a variety of activities suitable for seniors of similar ethnic backgrounds, such as language classes, music, entertainment, dance, yoga, Taiichi and physical activities.

I asked Audrey, a retired Indian teacher, how she engages in daily activities, and she described regularly going to a day centre for Indian senior citizens:

> *I keep my mind active and do something routine, meet people, go to church or outings, and that helps a lot. It gives you solace sometimes, peace and enables you to cope with many things. The more you go out, the better it is for your memory. When you are at home, you feel dull. People here have many governmental facilities, and we get excellent value. I mean free bus passes and the community association, which helps me, and others reach out to other seniors.*

Spending time with friends keeps Audrey's mind active and offers an emotional connection with people in her community. She praises the government for providing free bus passes, which enable her to meet others at the cultural centre, where the day-long activities help her connect. It gives her a sense of community belonging, which she sees as "suitable for [her] memory". It is important to note that Audrey connects to older Indian citizens from a similar background who speak her language; her story depicts interaction with people from her culture and community, and she recognizes that such activities help stimulate her brain.

Having a daily “routine” and undertaking diversional activities improve Audrey’s emotional wellbeing. On the other hand, she feels dull when sitting at home doing nothing. Interacting with people eliminates her dullness, provides comfort and helps her memory. Audrey “reach[es] out” to others and is pleased with what the government has implemented for older people.

The following story conveys the importance of the cultural centre for Lynette:

> *I use the ferry, train, and bus every Friday to visit this community cultural centre. I am very blessed. I am trying to do my best to meet people you know and be pleased. I still do a lot of housework and many other things because it is good for my memory and health.*

Here, Lynette emphasizes the harmony she experiences when visiting a local community organisation. She makes this long and pleasant weekly trip to meet people from her background, describing her weekly journey to interact with whom she senses a connection with a palpable sense of pride. One can fully immerse oneself in the meaning of this story—the extraordinary effort she goes about every week to be with others in the community, and she feels “very blessed”. Lynette’s activity shows her desire to develop and improve her social well-being because it is “good for [her] memory”. Lynette puts energy into socializing and is proud of doing chores when she stays home, which she sees as an intellectual incentive to deal with memory problems.

Susan reveals it brings joy and helps her memory being with other seniors:

> *I cannot go back to China very often. I am pleased to join the expatriate association every Tuesday and Thursday. We encourage people like social workers to visit us, so we encourage meetings, talking and laughing. Because I think having friends or somebody like that can help us. I feel the warmth and love we have in our community. Our social group regular meeting is the proper way to help with memory problems. We promote some social events and advise others at these meetings.*

Susan’s story shares her grief about not being able to travel to China very often, but she finds solace and happiness when interacting with other Chinese people at the “expatriate association”. It “help[s] with [her] memory problems” by encouraging “meetings, talking, and laughing”, which provides “warmth and […] love”. Susan seems to enjoy interacting with visiting professionals. She defines feeling relaxed and happy by expressing her thoughts freely. In interpretation, her interactions seem to show being connected with others to promote mind-boosting activities for older migrants at the cultural association. Susan “promotes some social events”, which she has confidence in improving her memory and fostering psychological well-being.

In Eileen’s case, interacting with the Chinese community helps her memory. She enjoys meeting other seniors to celebrate Valentine’s Day and being part of the same expatriate association as Susan:

> *I am pleased to be at our association every week, and everyone is happy with our activities. We have 200 members in the community association. Today we support Valentine's Day with sweet dumplings to serve our members. Over ten people come past early to help prepare over 700 dumplings. These events help bring happiness, which is good for our memory.*

Eileen's story highlights the importance of weekly interaction with her peers. She describes her "happiness" as being around other seniors making dumplings and serving other members of the organisation. Coming together for the Valentine's Day celebrations and arriving early to prepare the food seems an excellent way to intermingle. However, this activity is not just about making dumplings and sharing the food with others; it seems to be another way to connect with others which is "good for [her] memory" as well as bringing "happiness".

In the next section, I explore the phenomenon of older migrants being with family and friends as another form of connecting with others.

Being with family and friends

Connecting with family and friends is a form of social cohesion and a shared common purpose. Participants share stories about improving their emotional well-being when connecting with family and friends. This relationship seems to play a pivotal role for older migrants with memory problems. Connecting is part of "being with" to form the fabric of human experience (Heidegger, 1962/2008). Being with friends in the migrant community can help combat social isolation and loneliness; participants speak of such initiatives to keep the memory supple.

Lynette tells the story of being with her family, who are always supportive of her despite her experiencing physical and memory problems:

> *I usually live with my daughter and her family. My daughter thinks I am physically healthy, and she supports me. When I forget something, they help me. Now there are some concerns about my memory problem. I am not sure if it is the hearing or my brain. They are overly concerned about my memory and want the doctor to check it. So, I am apprehensive and want it checked too. In the meantime, to help my memory, I do housework and other minor jobs, which are also suitable for my memory.*

Lynette says she relies on the support of her daughter in her daily life to help her stay "physically healthy". Lynette acknowledges that her daughter thinks of her wellbeing, especially when she "forget[s] something". Her daughter wonders if it could be a "hearing" problem or her "brain" and wants a "doctor to check" to appease these concerns. Lynette helps her daughter with housework and "minor jobs", which are mentally stimulating activities.

Loneliness shows itself, despite being in the company of other people. For example, someone is surrounded by family members or friends but feels lonely. Some participants expressed their intention to be with like-minded individuals. Eileen likes to be with other seniors with similar cultural and social interests:

> *I am not interested in shopping anymore, but I want to be with seniors. Sometimes it is just to have a chat with them. When my daughter asks me to do something or go out for a few days with her, I don't want to, maybe because of the generation gap. Youngsters have different interests, and sometimes I want to enjoy myself with them, but I am too mentally tired for any activities. So, I rarely join family outings. A couple of days earlier, we had dinner at a restaurant. My daughter talked to her friend about work, and the kids played on their cell phones together. For me, I simply remain alone. I would rather stay alone or meet more friends of a similar age and have the same memory issues at the community centre. I hope to live with other seniors at the same rest home one day.*

Eileen reveals that she prefers to stay at home or be with people her age. She sees a "generation gap" between herself and young people. A great revelation is that she wants to enjoy life and engage in activities with her grandchildren but feels "too mentally tired". Eileen's tiredness is probably fatigue, and her memory is slowing down. She appears to feel much more comfortable staying at home or "meet more friends of a similar age". When Eileen describes her daughter talking to a friend while her grandchildren play games on their cell phones, there seems to be hidden frustration and disappointment. Maybe she wanted to spend time with them, which meant they would interact with each other while eating. Although Eileen is with her family, she gives the impression that she is uncomfortable; she would prefer to be with other seniors, which would benefit her. Eileen's story portrays her frustration with not enjoying quality time with her family. She accepts that being with other seniors is beneficial because of the age gap. Eileen considers living with other seniors in the future in the "same rest home one day". It seems she wants to spend time with like-minded people of a similar age.

The following story shows Susan's story on how her husband is essential in supporting her when she has trouble remembering day-to-day matters:

> *My husband always asks me how much it costs to go to something. When my husband dies, I am worried I will be sad because I cannot see my son-in-law and daughter here; both live overseas. I rely only on my husband and no other people. I had a friend with a similar memory problem, so I am afraid. I am worried about my husband because my memory is terrible, but not as much as his poor physical health.*

Susan talks about the help and supports from her husband, who regularly checks on her wellbeing. Perhaps she communicates her vulnerability because of her memory problems and therefore values the support of someone close, reassured by and "rely[ing]" on her husband. Susan conveys her fears and worries about when her husband will die in the future because her daughter, who lives abroad, will not be able to support her. Reliance on her husband is crucial to her well-being because of her "terrible" memory. Susan knows someone with a "similar memory problem" and fears her husband's fragility and ill health will jeopardize her memory problems.

Maya illustrates the importance of cell phone technology to connect with friends in her account. This seems to help her be less dependent on memorizing everything:

> *I am the chairperson of a cultural organisation and need to write everything for this organisation. I usually do it on my cell phone. Because I am a senior citizen, I should accept that I do not have an excellent memory. I use the phone to manage my poor memory because I dislike asking my friends the same thing repeatedly. For this association, I need help remembering what to do. We use the WeChat app like WhatsApp to connect with other seniors and some with poor memory within the Chinese group. Every day I spend time with other seniors in the WeChat group to ask questions or events for the organisation.*

Maya mentions that she is the head of a cultural organisation and does not rely on her memory to remember her daily activities. A cell phone seems to be her solution to "write everything" in it because of her memory problem. Maya spends much "time" with her friends in that community organisation. Relying on a cell phone appears fundamental for Maya's role as the head of that organisation. The use of cell phone technology seems to be a valuable device to remind her what to do every day and helps her "connect with other seniors". She admits she does not have "an excellent memory", which explains why she uses technology to keep up with activities. Maya acknowledges that her repeated repetitiveness (asking the same thing) is typical for a senior citizen with "poor memory". Maya's strategy of using the cell phone as a memory tool appears to be wise to help her memory problem.

Being connected spiritually

Connecting with others through prayer is an essential way of life for older parishioners, seeking spiritual comfort and perhaps an integral way to help with memory problems. Participants' stories show that they spiritually connect with friends and families when attending church. Being spiritually connected is essential for some participants, especially when there are memory problems.

Audrey describes how praying and mixing at a church helps her connect with others and alleviates her deteriorating memory:

> *Shortly after my family left the house, I got up. So, I don't get up together because this will add more chaos. They are all busy preparing to go to work. So, the first thing I do is go to the church near the park. Going to church is an everyday routine, yes. I mean, we go to church all the time. So, I do my prayers and rosaries and attend masses with my friends. You pray for whatever reason you like for yourself and others. I mean, people tell you to pray for them. You forget at the church because I have no concentration, and my mind wanders. Suddenly, when you ought to get up, I realize I'm still thinking about something else. Sometimes it is awkward because I sit and quickly get up when everyone stands. People wonder if something is wrong with me. When the priest reads something in the scriptures, it triggers something in my mind. Sometimes I think about something, like my parents who died long ago. Then my mind wanders about something else.*

Audrey reveals she gets up in the morning after her family has gone to work to reduce confusion. Perhaps highlighting her memory problems gets in the way. She goes to church, which is her everyday routine, and she tells of how its involvement aids her memory. Audrey finds comfort in "prayers, rosaries, and attend[ing] masses with [her] friends", which helps her connect spiritually and with them. She tells of praying for herself and other people. But she forgets as she has “no concentration, and [her] mind wanders” during the mass. Another disclosure is that a likely memory problem is staying seated instead of standing up with other parishioners. In another incident, while the priest reads the scriptures, it triggers her mind to wander elsewhere.

Lynette also likes to get involved with church community events regularly:

> *When I go to church every week, I try to get in touch with more people. I realize I cannot catch up when people sing hymns in church. For example, when everyone is singing on page 95, I cannot follow; I’m somewhere else. I am pretty slow and concerned that my brain is the problem.*

Lynette describes how she attempts “to get in touch with more people” in church. She struggles and “cannot catch up” singing hymns; she is often on a different page from the rest. It seems to be a lack of concentration on Lynette’s part, but her memory problems are apparent, too, while praying. She is “concerned” about her memory, hindering her from staying connected.

Gemma talks of praying at home and attending church to stay spiritually connected, prayer helping to stimulate her brain:

> *Usually, I get up early, pray and read the Bible. Then I have breakfast and get ready for my daily activities. On Saturdays and Sundays, I go to church to pray with other friends, starting at 9:30 am and returning home after 2:00 p.m. After church, I meet with friends. It is a friendly crowd; we have games, so I enjoy that very much. People at church are also very nice. That way, I keep my brain busy, which helps me improve my memory by praying and mixing with others.*

Here Gemma describes her daily and weekend routines and professes to improve her mental wellbeing by “praying [together] with others”. Gemma finds church activities useful for connecting spiritually and socially. She recognises that being with others, “praying”, and playing “games” together keeps her “brain busy” and believes this strengthens her memory.

Engaging in activities

For these participants engaging in daily activities that stimulate the brain, such as work and social events, is essential for improving physical and mental wellbeing and aiding memory problems. Participants reach out socially to their family and friends to give structure and connection to daily life. Being committed to regular activities can improve physical, psychological, and social wellbeing. Participants seem eager to describe the events that help them with their memory.

Joan speaks candidly about how staying at home makes her feel “lonely”, which does not help with her memory problems. She reports engaging in activities instead:

> *I am 70 years old, and my life is staying at home. It is not correct, and it makes me feel lonely. My husband died three years ago, and my two daughters live*

> *abroad. I have a routine daily schedule: Mondays and Tuesdays, I stay home and go to the public library for my class on Wednesdays. Thursdays, I do voluntary work at St John Ambulance in the afternoons. Friday mornings, I have an English reading class and, in the afternoon, this community organisation. I learn a musical instrument on Saturdays and go to church on Sundays. I also walk for two or three hours every day for exercise. So, I keep myself busy reducing my loneliness, which also helps improve my memory problem.*

In Joan's world, "staying at home […] makes [her] feel lonely". She engages in various local activities daily, such as English and music classes, and does volunteer work to manage her aloneness. Engaging in activities helps with her "memory problem". She also attends church and the Community organisation regularly. Joan seems to see these commitments as essential activities to support her physical and mental wellbeing, conveying that a busy schedule reduces her "loneliness" and taking part in these activities helps "improve [her] memory".

Audrey's similar message is of walking in parks around her home to help enhance her physical and mental wellbeing with mind-stimulating activities:

> *It is nice to go out there with people, like going to parks, which we rarely have in India, and they are not that safe either. I find it very safe here, even going to the chapel in the morning, a narrow lane close to it. Sometimes only one or two people use it, but it would be a scary experience when I was in India, but everywhere is safe. Sometimes people have a pleasant good morning or evening that helps me with my morality. This is good for my memory too. I need to keep memorizing things and keep my mind active. I enjoy reading books a lot, and I play Sudoku. I guess it helps. I love it, but not the challenging ones because I have no patience. My daughter and I watch many short films, but I forget the news or movie. However, when I watch a short film for a couple of minutes, I cannot remember seeing it. They often tell you what to do about your memory problems, like yoga, games, and meditation; that is extremely helpful. But grumbling and worrying about unimportant things do not help. I mean, worries are still there, and your health worsens. Sometimes I think it would help if a school were nearby; I would like to do some relief work and teach young children again. It would be nice to learn more about something, even from children. That also keeps your mind busy.*

Audrey describes experiencing a sense of joy and fulfilment when walking around her neighbourhood and meeting locals. Audrey tells of her passion for "going to the chapel", something she could not enjoy when she lived in India. Her previous experience was living in a "scary" place compared to the "safeness" of Aotearoa New Zealand. She crosses a narrow lane to reach her chapel daily, describing it as a pleasant journey. Audrey is content with this routine, especially when people greet her with a "pleasant, good morning or good evening". Living in Aotearoa New Zealand seems good for her mental wellbeing, which also helps ease her "memory" problem.

Audrey speaks of "memorizing things" to keep her "mind active". She explains that games such as Sudoku are helpful, but she has no patience anymore with "challenging" games. Audrey's lack of patience is another sign of her difficulty concentrating because of "memory problems". She spends time reading or "watching short movies" with her daughter and admits to "forgetting the news" or full-length films; unless they are short, she will "forget". This story explains Audrey's reasons for reduced concentration levels and "memory problems". Audrey promotes "yoga, games, and meditation" as helpful and says that grumbling or worrying about "unimportant things" worsens health. She would like to do "relief work" at a local school to help overcome her memory problems and improve her wellbeing. Audrey points to her past teaching role as a potential skill to use again and keep her "mind busy" by learning from children.

Audrey continues her story by showing the significance of engaging with her family to celebrate her birthday:

> *I have become quite forgetful lately, which was not like this before. I know exactly where things were in the house, but now I am confused. Doing nice activities helps. Once we went to Orewa Beach for my birthday, we had a lovely time there. I did not want my family to call people and party in the house. So, I thought it was best to go somewhere and have a quiet time with my family. My son-in-law does not get a break. He leaves early in the morning and returns at night. So, it was great spending time with everyone, especially with him. We played a couple of games, like 'Dumb Charades'. Like you enact the first name of a movie, tell them how many words it has composed of, two or three words, and either draw or show it out. So, that was a lovely day we played (memory) games together. Otherwise, I would have just sat and talked in the house. Otherwise, old memories always seem fresh in my mind. Sometimes all the old memories are intact, but now my mind is wandering around.*

Audrey remembers enjoying a "lovely time" on her last birthday, not wanting a traditional birthday at home but preferring to be with her family at the beach. Audrey clarifies that it was best to do something together and have a "quiet time playing with [her] family". Although she would still have been with her family if the party were at home, the beach was more appealing. While her older memories are still intact, she describes her recent memory as less than excellent; it "wander[s]". There is a sense of enjoyment when she describes being with her family and playing memory games. This activity involves recalling titles of old movies, which helps stimulate her brain.

Charles offers a distinct perspective on a dinner outing with his family, which supports his emotional wellbeing. It seems this is good for his memory and brings positivity into his life. His next story relates to his second son, who resides with him:

> *It was a total joy when I was told my daughter-in-law was pregnant. They took us to a restaurant and surprised us with a cake to congratulate us as new grandparents. This kind of information has just blown me away, you know. That is happiness, our first grandchild. Many people do not have that luxury or an opportunity, but it is my happiness. Another time, my son wanted a new car, and two weeks later, we went to the dealership with a cheque for a hundred thousand dollars, and he drove his car. He was as happy as Larry. That is happiness as well as positivity for my brain. It is simply this kind of positivity that carries me. This kind of happiness does not mean the material wealth I am chasing. No, it is mental satisfaction. We have worked bloody hard to get where we are. Remember, we were brought up in an apartheid South Africa, where you have been classified as non-white or white, and you had to wade through these muddles. So, once you get to this point in life, you feel you have survived and done it. Happiness, joy, and sadness depend solely on yourself. I know little about*

> *forgetfulness; it is when I completely forget something, but my positivity helps and carries me.*

Charles talks about engaging in a memorable moment that brought complete “joy” to his life. Charles’ dinner outing gave his other son the satisfaction of being connected with his family. There is an ontological knowledge of joining his family for a dinner outing as “happiness” that improves his psychological wellbeing. Charles’ story portrayed this outing as an extraordinary event when he was surprised to learn that his daughter-in-law was pregnant. An expression of “happiness” was evident when describing the news, “[it] has just blown me away”, with the happiness of soon becoming a grandfather for the first time. From his perspective, such good news is a luxury and “positivity that carries” him because it is an opportunity not everyone has. In interpretation, such memorable moments bring Charles happiness and give him “mental satisfaction”. Charles describes buying an expensive car for his son; the satisfaction it carries is not “material” but “mental”. He says he worked hard, referring to the difficulties of growing up during the apartheid era in South Africa, but now has a sense of happiness and positivity after wading through “muddles” to achieve his current wealth. Charles surmises that happiness, joy, and sadness depend purely upon the individual, acknowledging that he can now enjoy spending time with and money on his family after a hard life.

Charles continues his story of self-empowerment and the positive activities that reduce stress and stimulate mental wellbeing:

> *Believe me, if unimportant things are needed, do not bother. So, your mind is becoming lazy. I tell my children to stay hungry to achieve what they want. It does not mean having a bank full of money. Many wealthy people do not sleep at night, age fast, and have no social life, so how can this guy achieve? We concentrate on something wrong, and an idle mind is troublesome. Empower yourself and never stop being hungry. Not stimulating your mind is dangerous because you get rubbish thoughts, which got me where I am now with memory issues. If I disagree with someone, I resolve it and never go to bed with a problem. So, the mind does not go into overdrive mode, and it becomes stressful. For example, I am not worried about trivial things like no sugar in my coffee. It is this kind of positivity that carries me.*

According to Charles, mind-stimulating activities are crucial to improving his memory. He suggests that an “idle mind is troublesome”, and one should avoid letting the mind “becom[e] lazy”. Charles means not worrying about “unimportant things” in life and gives similar advice to his children, urging them to “stay hungry”. In interpretation, staying hungry perhaps means being hungry for new knowledge and reaching high. For Charles, it means not focusing on the wrong things in life, which leads to “troublesome” minds or evil “thoughts” he maintains the importance of a positive attitude. If people have differences, they should “resolve” them before going to bed, or their minds go into “overdrive mode”. Charles’ example is that worrying about “trivial things” can hurt someone emotionally. He promotes a positive mental attitude, helping emotional wellbeing and memory function.

Gemma finds that maintaining regular daily and weekly activities at the cultural centre help keep her mentally stimulated:

> *Monday, I go for a walk in the park, and then I go to a lady's meeting. Then on Tuesday, I simply do an activity at home, catching up on everything I do not do. I watch TV and talk to friends on video calls. Wednesday, I travel to the community centre to do more activities. On Thursdays, I sometimes go out with friends for a coffee. Fridays, I rarely go out. I am at home, and I go to church at the weekends. In this way, I keep my mind busy with some activities.*

Gemma engages in regular daily activities that "keep [her] mind busy". She talks about "walking in the park" and connecting with her friends. Gemma catches up with "an activity at home" and video calling her friends. She meets seniors at the cultural centre and "go[es] to church" on the weekends, all activities that improve her memory.

Similarly, Maya endorses physical and mental activities and concludes that these help her age graciously and boosts her memory:

> *I accept that I have a memory issue and feel unhappy. I am a highly active person, and I often go out. Certain things are impossible, but I need to do things slowly because I need to remember words. I must promote my daily social activities as much as possible. I must stay busy, be more socially active, be with good friends, and be more optimistic. Keeping my brain active can prolong ageing, like supporting other seniors in the cultural centre with more healthy living activities. I am glad and a little proud of what I am doing.*

Maya admits she needs to slow down as she has a "memory" problem, feels "unhappy", and believes she cannot do "certain" activities. For this reason, she is optimistic about "social activities" with other seniors and believes in keeping her "brain active", which stops her from ageing too quickly. To this end, Maya is proud to "support […] other seniors" in the cultural centre by promoting joyful activities that are mentally stimulating and directed towards maintaining a healthy lifestyle, active brain, and extending ageing.

Reflection

This chapter addressed salient notions of connecting with others as a form of "cognitive science" in face-to-face interactions involving an individual (Heidegger, 1962/2008). Phenomenology and cognitive science present diverse ways of looking at events to improve cognition. There have been some attempts to assimilate phenomenological insights and methods into cognitive science, drawing mainly on the works of Heidegger. Mental health knowledge is one of the most popular modern attempts to study the mind (Hollingsworth, 2015).

I have previously explained Heidegger's notion of "being with others" by illuminating the interpretative modes of how participants engage in activities. This study takes an ontological approach that examines connecting with seniors and using their stories as the basis for data interpretation. Participants describe various hermeneutic concepts of connecting with others by engaging, interacting, praying, and participating in activities, and show that this is not necessarily just about connecting with family, close friends, or fellow seniors. It also means connecting, sometimes in the spiritual sense, with other 'beings', places, cultural centres, parks, churches, and public areas. Individuals who participate in various cognitive activities are more inclined to maintain a higher level of cognitive functioning and be less prone to developing MCI and dementia (Weaver & Jaeggi, 2021). Cognition seems to be enhanced by daily interaction, illustrating the link between feeling alone, experiencing memory problems, and seeking assurance and ways to ease social isolation. Being connected with others is how individual experiences are shared. Heidegger (1962/2008) describes two notions of dasein, human connection: "being in the world" and "being with others" (Mitsein)[4]. This concept also proves the value of the relationship of human coexistence (Wright-St Clair, 2008).

In a human relationship, "mitsein" means that other people will coexist with it if there is a dasein. Heidegger's view of "being with" is essential to being human, classifying it as inauthentic when an individual fails to recognize in what ways that individual thinks of themselves and how they habitually behave as affected by their social surroundings. Hence, if an individual is unique to their world, the experience of togetherness with other people occurs (Critchley 2009). The connection with others is firmly based and interconnected with dasein.

Social isolation is not just about being alone but is a common, complex human emotion unique to many ageing people, especially those with MCI (Tiwari, 2013). Participants' stories show feeling lonely, which worsens psychological problems and experiencing memory difficulties (Qiu et al., 2009), anticipating the subsequent cognitive decline (Zhong et al., 2017). In "Being and Time", Heidegger (1962/2008) considers two notions of solitude and loneliness "Einsamkeit" and "Vereinsamung"[5]. Both have similar connotations, with feeling lonely or deriving from it as an integral part of human experience in the context of "being in the world" and "being with". Heidegger explains that "a bare subject without the world never 'is' proximally. Nor is it ever given. Thus, an isolated "I" without others is just far from being proximally given" (p. 152). An individual sets off to be with others relevant to "being with", which they do in their everyday lives. In other words, dasein does not mean "being with" and being isolated; it is still about "being in the world". "Being with" implies that dasein exists in this context, much like being alone. Heidegger would describe loneliness in terms of "Uncanniness"[6], which conveys a feeling of displacement and is literally interpreted as "not-being-at-home" (p. 188). Therefore, being alone is not helpful for someone with memory issues, such as Eileen, who feels lonely despite being with others. Conversely, being with others helps with cognitive stimulation (Luchetti et al., 2020).

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[4] Mitsein is a Heidegger term used with "being-with" and refers to an ontological characteristic of the human being that it is always with or already with others of its kind (Heidegger, 1962/2008).

[5] Loneliness (Vereinsamung) is not like solitude (Einsamkeit), which requires being alone. Loneliness shows itself most sharply in the company of other people. For instance, someone finds themselves surrounded by others, but they cannot establish contact with them, or to whose hostility they may be exposed. The lonely person, on the contrary is sate of aloneness. The person is on their own and therefore "can be together with themselves" as they have the capability to "talk with themselves" (Aho, 2022).

[6] Uncanniness: Another German word signifying "not-being-at-home", strange, and a further suggestion of uncanniness means feeling lonely (Heidegger, 1962/2008)

In the notion of “being in the world”, participants expressed feeling alone and later experiencing memory problems. Living with memory problems prompted some participants to connect with others as they found it reduces loneliness. There are other valuable strategies to combat aloneness, just as ways of being with others. Participants’ stories show how they continue to engage in routine activities and share experiences in cultural groups, initiatives that help unite and equip them with strategies to deal with their memory problems.

This chapter shows the heterogeneous ways participants with common memory problems connect. Susan’s account portrays her isolation and explains the enjoyment, warmth and love she experiences when interacting with seniors rather than family members. Pondering Heidegger’s philosophy, the phenomenon of “being with” shows that participants prefer to be with seniors of a similar age and culture. Similarly, Eileen describes her fondness for “being with” other Asian senior citizens with similar socio-cultural interests rather than shopping or dining out with her family. Being with others is her way of coping with her forgetfulness. In this regard, Heidegger’s idea of dasein alludes to human familiarity, which is uncommon to others—what contributes to Eileen’s response is apparent in her desire to be in an unfamiliar setting but not be with her household.

Audrey, Maya, and Gemma define family activities as another form of connecting with others, improving their mental wellbeing, and helping with their memory problems. Audrey described being with her family at the beach or friends in cafes as improving her emotional well-being. Being with family contributes to Heidegger’s theory of the “ontological foundation of anthropology and psychology and building them into the framework of a general biology the (science of life)” (p. 75). In the same context, van Manen (2014) pointed to understanding the realm of the individual by considering the knowledge of a phenomenon. Likewise, understanding the participant’s experience with family is a realm of human ontological interaction. Being spiritually connected helps Gemma keep her mind busy; her story is a notable example of the psychological benefits of praying in church. The philosophy of being with and praying with other people is a common ontological explanation of human spiritual connection. In this regard, Heidegger (1962/2008, p. 82) argues that “being in” should not be explained ontologically but by a deeper understanding of reality.

Heidegger’s (1962/2008) concept involves a deeper understanding of the existence of experiencing with others. Dasein connects people with memory problems in community organisations or family homes with activities to enhance the mind. Phenomenology shows that people are psychologically affected when there are fewer social connections, fewer physical activities, and not being with others (Aho, 2022). The study also shows that participants want to find other support mechanisms to avoid social isolation and improve their emotional wellbeing to help with problems with memory.

Summary

This chapter uncovers the notion of being connected to family members, friends and cultural organisations as a common experience for older migrants with memory problems; being with others enhances psychological wellbeing. From a phenomenological point of view, an insight into the lived experience of older migrants with memory problems sheds light on the concept of being connected with others. The impact of social isolation is detailed and emphasizes that humans are always with others and are never entirely alone in the world. Novel concepts were revealed about how older migrants interact with family and friends, at home, in community organisations and places of worship. Ultimately, older migrants with MCI are psychologically and socially vulnerable, and it helps to engage in mind-boosting activities.

In the next chapter, I explore forgetting everyday rituals—a continuation of the behavioural concept of how older migrants describe their lived experience with memory problems.

Chapter Six: Forgetting in Everydayness

This third findings chapter explores older migrants' experience of forgetting daily. It focuses on stories where forgetfulness is demonstrable in participants' day-to-day endeavours, has caused concerns, and exposed them to risks. Notions identify the difficulty of remembering routine tasks such as appointments and daily schedules. Some share similar frustration with being forgetful daily and impacting their health and wellbeing. Another notion describes older migrants' challenges, including recalling names and locations, misplacing items, preparing meals and similar daily activities. When the participants forget routine tasks, they express embarrassment and disappointment. Older migrants refer to cultural understanding, stigma and being kind and supportive of each other.

Being aware

Participants experienced frustration when they noticed the effects of being forgetful and realised the impact of memory deterioration. Maya explains how her memory has worsened over the last five years:

> *It has been around five years now. I slowly realized that I didn't know where I put things. But I suppose I recognised you in the last two years but cannot remember your name now. Sometimes I take a couple of minutes, or even an hour before, and I cannot tell you your name. I don't know my memory problem because nobody tells me I am getting worse. So, I don't know if that's because of the change in living conditions or because I'm getting old.*

Maya recounts her awareness of not being able to remember people's names and questions whether it is a normal part of ageing. Her main concerns are not knowing where things are in the house and not being able to remember people's names. She tells of her frustration with the subtle changes in memory patterns. She realizes she is unaware if her memory has worsened because family or friends do not comment about it, "nobody tells [her]" she has a memory problem, and she seems to accept this as part of ageing.

Eileen expresses similar apprehension when she becomes aware of her inability to recall an old friend's name:

> *My friends do not usually mention my memory problem, maybe because of politeness. We use the WeChat app on our cell phones. I had a long-term friend over 60 years ago when I was young, but I can't remember his name. When I ask another friend on WeChat, she says that person's name. I don't know why I couldn't remember his name.*

Like Maya, Eileen depends on friends to gauge her memory loss; she ponders why they do not mention it so as not to be considered rude. She uses WeChat to connect socially and asks others to help her recall an old friend's name. Eileen now knows that her memory problems are apparent, and she is not alone.

Kate is an 81-year-old Chinese migrant with memory problems. She notices her forgetfulness worsening over time:

> *In the beginning, I couldn't understand; I always forget this and forget that. For example, when I'm out, I'm halfway outside, and I realize I'm not sure if I locked the door or not. Then I went back and checked to find that I did lock the door. But it happened once before. Another day I did forget the house key. Then I had to walk around for a while outside the house and wait for my family to come back to let me in. This is a worry. But now I tie it around my neck, so I don't forget. My friends, too, are forgetful. Last time, I went to the park with them and forgot my bag on the bus. The society was perfect and helped arrange for an interpreter to communicate with the bus office to get my bag. Luckily, I got it back.*

Kate shares stories of being aware of forgetting certain things, "forget this and forget that", all the time. She seems worried about the embarrassment of returning to the shops. Kate highlights memory lapses, which worry her because they were one-off incidents but could lead to potentially more inconvenient situations. Communicating her memory problems is another challenge for Kate when she "forgot" her bag on the bus. She is prone to leaving things behind or locking herself out of her home. Forgetfulness in her daily life frustrates her, but she finds ways to get help.

Worrying

Some participants express anxiety when realizing they have memory problems. Stress can lead to significant anxiety (Chu et al., 2022). Such a psychological problem may lead to forgetfulness, confusion, difficulty focusing, and other issues disruptive in daily life (Livingston et al., 2020). The following participants' stories underlined the negative effect of distress, mainly through the misplacement of essential items.

Joan described her worries when she misplaced her passport before travelling abroad:

> *Last October, I went to my home in Korea. Your passport is a serious matter. Therefore, I put it and my money somewhere safe. When I had to leave the next day, I looked everywhere but could not find it. I could not recall where I put my passport. Then I called my friend, and we discussed this. She told me to go to the town for an emergency passport. My friend agreed to escort me in my car because it was a long way off. Once I got in my car and opened the glove box, I found my passport. Oh, I guess it was for safety that I put it there. When moving to a new home, it was a mess everywhere, and my car was the safest place, I thought, but I forgot. This one was severe worry and scary.*

Joan recounts being anxious about her passport when planning to travel overseas. Her plan to put the passport somewhere safe, in the glove compartment of her car, was reasonable, but that she forgot its location highlights a short-term memory problem. Joan feared the worst when she could not find it – she could not go to Korea and sought an expensive emergency passport, only to find the original in the "safest place". Joan reveals this was a "severe worry and scary" experience, which she attributes to the stress of moving house and needing a secure place. Her forgetfulness is an issue because she forgets the safe area. Joan's anecdote of relying on her memory to keep something essential is worrying because forgetfulness began emerging in her daily routine.

Susan describes being stressed about misplacing a significant item that she was planning to wear at a community organisation:

> *Once, I had to wear specific clothing due to Valentine's activity at the association. For example, I know I had to wear a red T-shirt. Then I looked here and there and could not find the red T-shirts. It took me a long time to search for that T-shirt. I can't see this, and I find that that's the memory problem; it was stressful.*

Susan feels anxious when her memory lets her down; she could not find a red T-shirt to wear for a "Valentine activity" at her community centre, "I look here and there", and the urgent search was stressful. Susan notices her memory has been affected by her inability to recall routine things. It seems her memory has deteriorated, impacting her daily life.

Tracy is an 81-year-old Chinese migrant who describes anxieties regarding her forgetfulness, which affects her wellbeing:

> *It was unclear when it started. A few years ago, I became a bit forgetful. But now I'm worried it's becoming worse. Before, I could remember names, and now I seem to forget. I go outside to exercise in the early morning, and sometimes I go out to buy groceries. When I buy groceries, I forget to take them home, leaving them there. I can't do anything about it, then. I cook and eat a little less until I go again next time. Many times, I have forgotten the bus schedule. I missed it and got fined because I could only use the bus between 9:00 and 3:00 p.m. Then I needed to go off to the bus station to get it fixed. So, it is a dilemma.*

Tracy describes memory deterioration over time and mentions her inability to recall names. She often "forgets" her groceries, leaving them in the store. As a pensioner, she has a concession card for free travel on public transport within certain hours; she recounts inadvertently boarding the bus outside these times. In her other story, Tracy might have been embarrassed to return to the store to look for the food item she left behind and was forced to "eat a little less". Her anecdote shows that Tracy has memory problems, is vulnerable, and sometimes goes without food to avoid shame. Tracy's story reminds us that ageing with memory problems is stressful and triggers everyday challenges for older migrants with MCI.

Catherine articulates forgetfulness and ageing in her daily life as a complex issue:

> *I'm old now, so my mind is not as right as young people's. It's hard to get old or age over time. I left the key in the car a few years ago and could not get inside. I remained there, and there was nothing I could do. Once, I left a handbag in a shop, and when I walked to the car park, I realized I had forgotten my bag. Luckily, the shop people kept it for me. One time I came to this place [community organisation], and I forgot my belongings. I forgot to bring the house keys here, and then I called my husband to get them. Most of the time, I forget about this and forget that. When I go to the shop for my grocery, I forget what to buy. Then I must go back to the shop again. However, it's not a big problem as I can still cook. Another time I forgot my house key and could not get in the house. Luckily, I had my cell phone and called my daughter-in-law. She came home and opened the door for me.*

Catherine admitted to several routine incidents when her memory failed her, forcing her to rely on the good grace of her family and others to help. However, she associates an essential sense of worth with her continued ability to cook for the family and is grateful that her memory does not affect this task. She says her memory is “not as right as young people’s”, accepting that an ageing memory is typical and expected in an older person.

Feeling disappointed and embarrassed

As in the preceding anecdotes, participants discuss incidents of feeling disappointed or embarrassed when they are forgetful. These occur when engaging in daily operational tasks and household chores. Many also leave them feeling embarrassed because of memory problems. Questions are raised about the continued vulnerability and well-being of older migrants with MCI, exemplified in Audrey’s story:

> *Sometimes I tell somebody to meet somewhere, then I forget about it. On one or two occasions, I remember missing one event. My friends call up and say, what’s wrong? Are you okay? Then I realized I told them I would meet, yes. That made me think about lying because I forgot to look at the calendar. I believe nothing terrible or severe has happened, but just unimportant things. But I feel afraid and disappointed when I forget something vital, and that’s trouble for everybody else.*
>
> *Once, my grandson left his jeans to stitch a button. Then I was embarrassed when I forgot to do it, and I remembered when he came home and wanted it. Sometimes my daughter tells me to do something in the house too, as soon as she comes home, I have forgotten! I feel ashamed and disappointed. I have nothing to do, and at least I could do something to help my family. They have done a lot for me. My daughter has a lot more patience, but my grandson is still young and gets a bit angry. He later says, “don’t worry and get upset if you don’t want to do it; just tell me”. So, I say it’s not like I don’t want to do it, but I’m just a bit forgetful sometimes, but then he realizes.*

Audrey characterizes her forgetfulness by enumerating incidents when she did not finish basic tasks for the family. The most challenging part is her deliberations concealing her memory problems with a lie to avoid the shame of disclosure. Audrey wishes to maintain the routine of keeping up with shared plans with her friends. Her strategy for remembering dates and tasks is to note them in a calendar to avoid disappointing herself and others; however, she sometimes forgets to check them. Audrey suggests “nothing terrible or severe” has happened so far and describes her forgetfulness as a minor problem but worries it will worsen. It seems routine is no longer ordinary for Audrey, as forgetfulness manifests in her daily life and makes her feel embarrassed.

Next, Audrey reveals awkward moments—forgetting to stitch a button on her grandson’s jeans and doing various chores for her daughter. Again, memory problems appear to stand in her way of remembering to do these tasks. She describes feeling “ashamed” because it was the “least [she] could do […] to help [her] family” on both counts. Audrey expresses appreciation for the reciprocity of giving back to her family but cannot fulfil the commitment. She has a sense of belonging to her family but feels guilty about her forgetfulness. Despite her grandson's apology, she is upset to have let him down. Audrey's concern about this situation illustrates what counts most to her family harmony and her eagerness to please them by doing what she can. Amid her difficulties in remembering, Audrey hopes her family realizes her plight.

In another anecdote, there is a further embarrassment when Audrey forgets to turn the house alarm off:

> *Last Saturday, I always put on the house alarm before leaving if I was the last. Sometimes I forget whether or not I put it on. And then, once I come back, I make it a point, tell myself, and set it off. Some friends came home with me once, then we went inside, and the alarm sounded. So, it has happened about three or four times now. The alarm was still on as we entered the house because I had forgotten to put it off. Then when we got in, the alarm went on. It was confusing, running here and there and wondering what to do next. Very scared initially, the next-door neighbours came. Then I said I'm genuinely sorry I forgot to put it off. It's a very frightening thing. I don't want to be like that. The fears of forgetting and not knowing what to do worry me and embarrass the neighbours.*

Audrey finds her forgetfulness "frightening". When she forgets to unset the alarm, she recounts the chaos of "running here and there and wondering what to do next". She was disappointed by her mistake when her neighbours came. Her apology also comes with guilt for her actions and her inaction. This anecdote encapsulates how much is unknown about Audrey's memory problems. There may be more happening in her real life, and she is embarrassed when her friends realize her mistake; the seriousness of her memory problems is revealed. Her fears of forgetting daily things may signify that her memory will worsen, which is scary for her.

Burning food is a concern for Mary, and she feels disappointed when this occurs:

> *I do not feel well and happy* [depression disclosed earlier]. *That was about three or four years ago when my memory deteriorated. Once I went to the kitchen to get something, I suddenly forgot. So, then I must go back and think. I forgot to turn the cooker off and exercise with my friends while cooking. Suddenly I remembered and promptly called my daughter-in-law to turn it off, but the food got burned. I'm disappointed with all of this.*

Mary recalls this event when she suffered psychological health problems and was unhappy, leading to her memory deterioration. Mary relates going to the kitchen to look for something, but, to her dismay, she could not remember what she was there for. She recounts other incidents in the kitchen of "[forgetting] to turn the cooker off" and asking family to help. Sadly, on that occasion, the "food got burned". Here, Mary's memory problems evoke frustration in her everyday life that stems from her health problems.

Susan was alarmed to find there was not enough food in her fridge:

> *Sometimes, when I want to eat something, I need bread and milk and so forth in my everyday life. Then I opened the fridge and found no more milk or bread. Then I must go out and buy it. Before my memory trouble started, I had nothing to eat at home. Now I'm ashamed about this and must write down what I must do. I often look at what I need in the kitchen to see if I need more salt, sugar, vinegar, etc.*

Susan articulates how memory problems play a significant role in her everyday life. She depicts frustration at discovering there is “no more milk or bread” in the house when she wants to eat. Her story conveys the impact of memory lapses, shedding light on her constant disappointment exemplified by this upsetting experience. Susan recalls having plenty of food supplies before her memory problem started. Now she must routinely write a list—the potential consequences of insufficient food and drink at home highlight her vulnerability as a senior. Susan’s words seem shrouded in frustration; awareness of memory loss reveals a more profound embarrassment.

Frustrating

Remembering day-to-day commitments is another problem revealed by participants. Anecdotes reveal forgetting basic things or experiences in everyday life that participants would typically have remembered in normal circumstances. The ordinariness of such activities exacerbates participants’ worry about their memory.

Tracy tells of spending more time at home now. She is frustrated because she cannot perform once familiar tasks:

> *When I’m going somewhere else, I always get lost finding directions. The biggest worry is memory loss. Due to this memory problem, I don’t go out most of the time. I always come here for this Chinese community association, so I remember the way. I don’t get out because my husband says you’re always lost. It’s best not to get out. So, I just watch TV, and I don’t go out. I thought two to three years ago, and I led this group. But because my memory problem was getting worse, I couldn’t do that. I remember it’s frustrating that I always forget something. I couldn’t take care of the accounting and had a language problem; I didn’t understand English.*

Tracy’s story illustrates her concerns about not “finding directions” when she goes out, taking care of accounts, understanding English, and stepping down as the leader of the association. Even though she remembers some familiar places, it worries her husband, who asks Tracy to stay home to avoid getting “always lost”. Tracy watches TV instead as her memory presents more problems. Tracy’s story illustrates how these insidious concerns hamper performing previously routine activities. Forgetting her traditional skills, being socially isolated, and ageing with memory problems underline her fears and frustration. A sense of vulnerability that shimmers around her life is described here, leaving Tracy almost unable to leave her home independently.

Forgetting his wife’s birthday is a frustrating situation for Charles:

> *There are small things I tend to forget, for instance, my wife’s birthday. So, two days before, I knew it was her birthday coming. It simply slipped my mind completely. So, when I take a fizzy in the morning, we share it and take her to work as usual. I forgot about her birthday, man; you know. I forgot to wish her. So, when I picked her up at half-past twelve from work, I remembered and waited for her then. I’m wrong about recollecting. It just totally slipped my mind. I even forget my birthdays, believe it or not.*

Remembering birthdays is significant for many. However, it seems a trivial matter for Charles. Charles' anecdote points to the anxiety of forgetting his wife's birthday and downplays his forgetfulness as a "small thing". He remembers sharing a fizzy drink with her before she went to work but forgetting to wish her a happy birthday. On this occasion, Charles is dismayed that the birthday "slipped [his] mind", which is another reason he feels embarrassed. At one point, he admits to "forget[ting] my birthdays" and wondering if people believe him. Charles' words convey a form of mental weariness that is routinely familiar in daily life, as noted here and in his other stories. Charles is understandably not used to forgetting such events, but his memory problem is evident.

Eileen tells of her frustration that she can no longer do math calculations. Engaging in mental arithmetic is good for her memory:

> *When I was young, my brain was entirely correct. Even better than some. I had a good memory when doing mental math. For example, when I was working in a restaurant in China, there were different bowls of food; one bowl cost more, and another bowl had a different price. I had to remember the price of more than ten bowls or plates at a time. After people ate, I could say how much one had to pay without using a calculator. And it turned out my calculations were perfect. But now I'm frustrated that I can't do so well with my account, and I have a much weaker memory because of my old age. I think it ought to be more reasonable with people getting old.*

Eileen clarifies her frustration and difficulty in making mental maths calculations, which she attributes to an older age. She relates the anecdote of working in a restaurant in China when her younger mind was "entirely correct". Eileen explains her math skills by calculating multiple food orders with varying prices without a calculator. She recalls the precision of her account as being "perfect". Now she has a much "weaker memory" due to ageing, which is "reasonable" in her view. Eileen reveals the impact of ageing with memory problems upon her predicament and illuminates mental weaknesses. Her frustration shows up amid typical day-to-day affairs that once were mundane but now seem complicated.

Repeating

Repetitiveness can emerge amid deteriorating memory problems, manifest in reiterated typical conversations. Participants with memory problems feel demeaned when they unwittingly repeatedly state or ask the same thing, an experience that signifies everyday frustration and humiliation.

Susan is cognizant of being repetitive when communicating with her daughter:

> *Because my memory is not good at times, I speak a lot, repeat, and repeat. When I had a phone call from my daughter, she told me; I repeated the same thing; I didn't notice it, but my daughter said nothing and supported me. I am appalled.*

Susan reveals that she tends to "repeat" herself during the "repeat, and repeat" conversations. Her repetition and memory problems are linked, which she finds appalling.

Susan does not notice when this occurs, just as her daughter does not mention it but is supportive. Susan is aware that her repetitiveness is habitual. She cannot avoid it.

As in the previous story, Maya admits how repetitive she is and is concerned about this issue:

> *My husband and my daughter did not realize my memory problems at first. They say I have become too repetitive and talkative in the last two years because I repeatedly say the same thing or ask the same questions. What affects me the most is that it's noticeable because I often ask for something in the house. Sometimes my daughter tells me she won't be home for dinner. Then I forgot and put away the stuff we loved to eat for dinner that night. However, my friends don't realize my problem very much, but I'm more concerned and uncomfortable when this happens. Once, I had a doctor's appointment. They called me, why are you not there? Oh sorry! I have mixed it with another date.*

It seems evident that Maya has memory problems, and she notices herself being "repetitive" and "ask[ing] the same questions". Maya refers to her daughter, explaining that she would not be home for dinner. Still, Maya prepared food her daughter enjoyed, underscoring how her forgetfulness caused humiliation and discomfort. Maya thinks her friends do not yet notice her repetitive behaviours but predicts how uncomfortable she will feel when they do. She also conveys her embarrassment in overlooking a doctor's appointment and fudging when the receptionist contacted her. Maya's story relies on someone reminding her of basic things, a poignant example of how forgetfulness infiltrates daily.

Gemma worries people are impatient with her because she repeats the same message:

> *Other people and my daughter are impatient with me. For example, she knows I like salmon and makes sure she makes it for me. And I continue to ask her the same thing. When I asked her for a second time, she said: "I told you so many times". So, she repeats herself because I can't remember things. Sometimes I'm slow to catch up. She can't accept me that way because she hasn't seen me like that before. Before, I worked as a technical schoolteacher. I was so bright, and now the concept has changed.*

From her daughter's impatience, Gemma seems aware of friction caused when she repeats the same message, for example, her preference for salmon. Gemma tells of being "slow to catch up" and wishes her daughter would admit her mother's failing memory. She surmises that her daughter's uncomfortableness: "I told you so many times," is a lack of acceptance, becoming a source of tension and concern for her. Gemma recalls her time working as a schoolteacher. She tells of previously being intelligent and "bright", but her identity has changed because of her memory issue. Once comfortable in a world where she remembered things quickly, Gemma is now more repetitive in her daily life. She has adjusted to being forgetful repeatedly.

Stigmatising

Older migrants come from diverse cultures, and their families demonstrate various tolerance for accepting someone with MCI. Participants depict forgetfulness as a concern in their respective cultures, with different meanings attached.

Lynette depicts her knowledge of stigma in her culture concerning memory issues:

> *I am a firm believer, and in my own culture, we do not have brain stigma, or, you know, for mentally ill people. There is no one with dementia or Alzheimer's in my family, and everyone supports each other. My daughter is still supportive of my health problems.*

Lynette likens memory problems to having dementia in her Korean culture. Although she says no one has dementia in her family, she has concerned that memory problems are construed as dementia, which has a similar stigmatizing stance in her culture. She says stigma related to "dementia" is not a big issue in her family because they all "support each other". Lynette's household follows the cultural 'filial piety' concept, expecting the children to honour their family and care for each other when they are ill and older. In keeping with this idea, Lynette's daughter should care for her mother and support her through her memory issues, which she does. Lynette's experience adheres to cultural and familial values and influence.

Meanwhile, Anne points out that stigma was a problem before in her culture, but not anymore:

> *I do not think we have any stigma or similar things for people with memory problems in my culture. We try to understand the chain of life and support each other. It was a personal stigma issue in past Korean society, and it was reasonable for someone with dementia to think that way. In the 1950s and 60s, some people thought you had sinned or there was Satan in your body, but nowadays, no one thinks like that, at least not the whole country. Before, they did not like to speak with that person. But more people accept it these days, and opinions are now different. I do not think that kind of phenomenon exists. It is all gone in our society.*

Historically, the stigma attached to memory problems appears to be a core issue in Anne's culture. However, she says it is not the case anymore. Anne also relates "memory problems' to "dementia". She reveals that people from her culture try to understand the "chain of life", which she explains as being more accepting when someone has memory problems. Anne mulls over the attribution of mental health stigma, which people had a few decades ago when conversations about someone with such issues were avoided because it was construed that they had "sinned or there was Satan in [their] body". Anne is more comfortable that this social stigma no longer exists with the new generation's acceptance of mental illness. Anne's family members deem it morally and socially suitable to accept and care for those with memory problems in other cultures.

Ida is a 56-year-old Tongan migrant with memory problems. She points to the tribal tradition of her culture when people have a memory problem:

> *I was raised in Tonga, and people there has a way of caring for their families. It is within our cultural tradition to do this. If anyone has a memory problem, the family will take care of them until they are well. For this memory issue, I know people get it in their 90s but not when they are younger. I know people said before that it is karma, and they must have done something wrong in the past when they had such a mental problem. All over the world, as well as people here, believe that. That is true, but memory problem is like mental illness.*

Ida tells of her Tongan upbringing and conveys the “cultural tradition” of family caring for sick people. As in Lynette’s case, Ida’s culture follows a similar ‘filial piety’ concept. She recounts “memory problems” as a similar mental health illness for those in their 90s but not younger. Ida stresses that memory problems are “karma” for doing something “wrong in the past”. Karma seems to be a familiar issue in her culture for someone with memory problems attributed to a similar cognitive problem.

Being kind

Some Asian participants point to how Confucian philosophy influences their view of caring for people with memory problems. Confucianism was the dominant philosophy in Imperial China in 221 BC and continues to inform opinion in this century (Senel, 2020). The responsibility for caring for someone with memory problems is to be kind to each other. But caring for the sick is believed to extend to the entire family if someone has a health problem.

Maya conveys such cultural views and cites this philosophy as a guide:

> *Confucius was a highly educated learner more than 2,000 years ago. I’m not very good at Chinese history. He has written many books, and people call him the teacher of all teachers. We learned not to look down on people with memory problems; for the Chinese people, Confucius is important. We need to be sympathetic or kind to them.*

Maya recalls learning about Confucianism, describing Confucius as the “teacher of all the teachers” and a distinguished Chinese philosopher. According to Maya, in Confucianism, one must “not look down on people with memory problems” but be “sympathetic or kind”. Maya seems to adhere to this philosophical view and embraces its wisdom around memory problems. She seems compassionate and feels family must be kind to those with memory problems.

Eileen also points to Confucianism and the significance of being kind to others, particularly when someone has cognitive problems:

> *In China, things are different, not necessarily because of religion. Because of Confucius, the teacher, we began learning this in childhood. We had the teaching to be kind to our parents. So, it is customary for us to take care of our parents. How can we afford to live if the children or grandchildren don’t support us? During the Qing Dynasty, there were wars during the early 1900s, and there was no pension for anybody. But now, those who go to work and retire have pensions nowadays. So, we need our kids to support our lives, and we have health problems such as memory problems.*

Eileen speaks of learning cultural traditions as a child, including Confucius's philosophy and China's Qing Dynasty, believing in "being kind to our parents". From this teaching, children and grandchildren need to be kind and support their parents. Eileen explains that there were no pensions for seniors in China in the 1900s; children were expected to help their parents when they were old, according to the principles of Confucianism. Eileen believes her children should "support" her because she is a senior with memory problems.

Returning to Kate, she considers her family's kindness and support is crucial to fighting her memory difficulties. Nevertheless, she admits to feeling anxious because of family frictions, particularly regarding her forgetfulness:

> *Although we talk about it, we are tense, and it causes friction. My daughter and her family support my memory problem but say nothing. I think they don't want me to be a burden. My family is genuinely kind and supportive. They remind me of when I forget something. Before I go out, they ask, "have you got your bag or your keys or your umbrella". My family told me to be happy and "not too stressed". They make sure I get three meals to eat and have a good life.*

Kate enjoys family support with consistent reminders when she "forgets something". She says her family is "kind and supportive" but acknowledges that her memory difficulties can create tension. These conversations make Kate feel burdensome to her loved ones. She mentions that her family regularly reminds her to take "your bag or your keys or your umbrella" before going out and tells her to be happy and not "stressed". Kate also says that her family ensures she gets "three meals" daily. She is pleased that her family does not dwell on her memory problems and focuses on having "a good life". Regardless, easing potential tensions between family members about her memory challenges is a constant concern. There seems to be a deep connection with her family, who is kind and supportive of her.

Reflection

Participants' stories highlight awareness of being forgetful in everyday life, which resonates with self-directed anger, self-blame, and self-criticism (Tangney et al., 2007). The emphasis of this chapter has been on examining forgetfulness in the day-to-day life of older migrants. With regard to phenomenology, Eldridge (2020) suggests that early theory on forgetfulness is portrayed in time awareness and passive synthesis. Eldridge argues that the inability to recall is a significant issue because of forgetfulness, as they are irreducibly linked to the current situation. Heidegger (1962/2008) mentions a similar description regarding "forgetting of being" (also being abandoned) to describe various aspects of Western metaphysics (p. 97). Based on this theoretical perspective, understanding forgetfulness is crucial to past transcendent issues and their impact on memory. As such, Kral's (1962) term "benign senescent forgetfulness" appears to describe individuals with mild memory deficits, which is referred to as forgetting every day in this chapter (p. 257).

In my understanding, forgetting is a common phenomenon in an older migrant's life. This study emphasizes stories of being forgetful or doing repetitive behaviour that has made participants feel uncomfortable with their memory loss (van Wijngaarden et al., 2019). Eldridge (2020) lays out the subsequent connection to the notion of the transcendental constitution of being forgetful: “without forgetting, neither memory nor retention suffices for a consciousness of the past as past since both are irreducibly connected to the Living Present” (p. 401). Being forgetful is interpreted as understanding the past, which affects an individual’s daily life. The type or severity of forgetfulness described in participants’ stories merits a transcendental constitution of past events. As described in Chapter Four, “Being thrown into the distressing event” appears to be related to how the “thrownness” influences older migrants to forget daily.

Phenomenologically, Heidegger (1962/2008) refers to the term “Seinsvergessenheit”[7], which has relevance to forgetfulness or “forgotteness” (p. 97). Heidegger also posits the term “Nihilism”[8] in the same context, related to the fact that we live in an ever-changing world. Nihilism is associated with a sense of “abandonment by Being” or the “forgetting of Being” (Heidegger, 1962/2008, p. 97). In these notions, Heidegger seems closer to interpreting what contributes to people’s expressions and self-awareness about memory problems. Heidegger conveys to us the world older migrants live in and alludes to how some face a simple form of forgetfulness in the sense of “forgetting of Being”. According to De Beistegui (2003), a memory problem is similar to a state of abandonment. Forgetting each day is a remarkably identical connotation to abandonment, which Heidegger refers to as overcoming the tradition of “metaphysics” (p. 83). Metaphysics looks at the fundamental nature of reality, including the relationship between mind and matter, which Heidegger outlined in “Being and Time” (Heidegger, 1962/2008, p. 97). Heidegger also relates “Being and Time” to the involvement in developmental psychology and mental philosophy that brings new insights into the philosophy of memory. Heidegger’s insight into the mind’s interactions with the body contributes to inquiries into the term “problem of other minds” from within these research areas (Heidegger, 1962/2008, p. 45).

The first notion in this chapter illustrates ‘being aware’ of forgetting every day. This concept demonstrates how participants noticed their present ability to remember differed from the past. Their anecdotes highlight the ontological idea of being aware of ageing with memory problems. As van Manen (2014) puts it, dasein always occurs in just a way that “consciousness is not not-yet reflective or active” (p. 83). Van Manen’s notion of “not-yet” is often stated regarding a form of “Being-toward-death”. Heidegger (1962/2008, p. 255) similarly construes this notion as “coming-to-an-end” or having diminished consciousness. The concept of “not-yet” indicates moving towards the end of an event or circumstance as it degenerates further. In my understanding, Heidegger’s view does not suggest that someone’s forgetfulness means that

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[7] Seinsvergessenheit is conveyed by Heidegger as forgetting the mystery or secret of Being, which is the ‘ontological difference’ between Being and beings, i.e., between some concrete revelation of a world and the conditions which make possible any revelation whatsoever (Bartky, 2008).

[8] Nihilism is another German word demonstrating a sense of abandonment of being. Heidegger referred to the goals that increase in themselves and change human beings.

they are near the end of life but signals the end of a previously enjoyed good memory. In recognizing this, participants realize the significance of losing their once-good memory.

The notion of ‘worrying’ concerned participants when it affected their daily lives. van Manen (2014) interprets this issue as prejudices against common sense in everyday life. His phenomenological understanding of a “state of feeling” suggests being worried or experiencing angst (p. 32). Such feelings demonstrate the impact it has on memory. Anecdotes illustrate participants’ emotional vulnerability due to their memory problems. The concept of angst highlighted earlier is an example of events that reveal the nature of dasein in this world and its effect on memory, stress, fear, and angst. On this issue, Heidegger (1962/2008) declares that when a person is experiencing such a state of mind: “Dasein is always brought before itself and has always found itself, not in the sense of coming across itself by perceiving itself, but in the sense of finding itself in the mood it has” (p. 174). Participants constantly worry, there is no release, and they reflect their mood in dasein. These emotions are at the forefront as they go about day-to-day activities, impacting their memory.

Participants ‘feeling disappointed or embarrassed’ is revealed in other anecdotes. On this notion, Heidegger (1962/2008) points to ‘Being-together’ in contrast to the “Abandonment by Being” (p. 306), wherein he looks beyond the notion of being forgetful to the source of the questions. I highlight the origin of memory problems in participants' stories, highlighting disappointment and embarrassment as routine occurrences. Heidegger points toward looking at interpreting the forgetfulness in the world of the individual. He suggests that “even forgetting something, in which every relationship of Being towards what one formerly knew has seemingly been obliterated, must be conceived as a modification of the primordial Being-in; this holds for every delusion and every error” (p. 90). Participants such as Audrey, Mary and Susan expressed such disappointment, shame and embarrassment that contributed to their memory problems.

‘Frustration’ of remembering regular engagements was critical for participants with memory problems when misplacing belongings and finding it frightening and disconcerting. Anecdotes reveal diverse understandings of misplacing personal items and a lack of awareness of where they are. This may be age-related, but it is about “being there” and has forgetfulness as an issue. Being in the world has consistently been depicted as a state of mind (Heidegger, 1962/2008, p.172). The fear of forgetting important matters and how to perform crucial skills is compared to a state of mind. Experiences of failing to learn something new, remembering how to cook, directions or noteworthy events can contribute to memory loss since it affects “being there”. Participants’ memory problems may embarrass others, and their stories embody complexities experienced daily; concerns about the past affect them in the present.

In the cultural context, stigma is a significant element in the lives of older migrants. On this matter, Heidegger’s (1962/2008) concept of ‘historicity’ emphasizes that individual culture and tradition constitute being out of dasein (p. 18). The stigma of memory problems is reflected in family values and cultural practices. In this regard, Heidegger illuminates the ontological environment of culture as the “Being of Nature” through the guidance of “Being-in-the-world” (p. 84). The ontological conversation of Heidegger points to the “Being of Nature” as a description of existence in this socio-cultural structure. Heidegger suggests that cultural systems can affect cognitive health. Heidegger’s interpretation of being forgetful is a form of nihilism, which he describes as not “Being-with-others”. “Being-with-others” is always the Being of some entity; the Being is not some higher order waiting to be discovered (p. 149). Forgetfulness continues to be a controversial cultural description of the essential nature of existence, which Heidegger refers to as “fleeing in the face of it” and forgetfulness (p. 69). The results point to a link between people’s experiences of MCI, on the one hand, and dominant socio-cultural vision, on the other. Certain socio-cultural groups’ common concepts and stories, involving moral claims about society’s fundamental values, guide how they imagine their existence (van Wijngaarden et al., 2019).

In interpreting participants’ experiences of forgetting every day, it is vital to consider Kitwood’s (1997) “person-centred approach” as a guide for its philosophy. Kitwood’s views have inspired a marked change in the understanding of ‘being kind’ to people with cognitive problems. A person-centred approach emphasizes the importance of being kind to others, wherein everyone should be recognized and respected as unique in their family and socio-cultural environment. Heidegger’s (1962/2008) reference to forgetfulness as a phenomenon of ‘historicity’, “showing-itself-in-itself, signifies a distinctive way in which something can be encountered” (p. 54). The question is how to understand the personal experience of forgetting daily events but being kind to each other helps to eliminate this discomfort.

Summary

This chapter covered the experience of participants’ being forgetful every day; they described daily recurrent events when they were oblivious and frustrated by this. Notions such as being aware of forgetting names and places, feeling anxious, experiencing disappointment and embarrassment, and being repetitive, were emphasized. Other ethnically sensitive sub-notions have described the stigma in some cultures and the importance of family members, being kind and supportive of each other, and the importance of family values and tradition. In a philosophical framework, memory problems experienced by older migrants in their everyday lives, such as personal discontent and negative connotation, are firmly established in different phenomenological interpretations.

The next chapter describes how participants describe making sense of memory issues.

Chapter Seven: Knowing How to Make Sense of MCI

The previous chapter covered stories of participants’ forgetfulness in their daily lives. The notions portrayed their awareness, worries, frustrations, embarrassments, disappointments and understanding of stigma and being kind to one another when someone has memory problems. This last finding chapter reveals the notion of knowing how to make sense of MCI.

Insight into the significance of MCI and capturing participants’ experiences of managing their memory problems was a significant focus of this study. This chapter draws on participants’ stories to reveal the knowledge of how they experience MCI, their strategies to deal with their memory problems, and how they make sense of this condition. Participants’ stories show their experiences engaging in many individual activities to get around their memory problems. Participants reveal discomfort or uneasiness when experiencing MCI. Other aspects show how they make sense of MCI, express fear of dementia and use positive strategies for improving mental stimulation.

The concept of knowing shows how the participants interpret or understand what happened to their memory. In phenomenology, “knowing” denotes interpreting multiple stories with collective and recurring themes (Clandinin & Connelly, 2000). Knowing how to make sense of memory problems is about understanding how knowledge is gained. It is a form of intuition based on gut feeling and probably guided by our emotions (Clandinin & Connelly, 2000). The perception of knowledge is a physical issue that needs to be recognized: “we shall need to reawaken our experience of the world as it appears to us in so far as we are in the world through our body” (Mol, 2021, p. 2008). Knowing also encapsulates how the participants encounter the lifeworld: “these subjective moments of knowing are the lived-through experiences” (Koopman, 2015, p. 2).

Knowing how it happened

The first notion reveals how several participants reported seeing a doctor to confirm what was affecting their memory and ask for treatment or help. In this study, participants with MCI were initially self-diagnosed and contacted by a doctor to clarify their symptoms to seek help with treatment. The first participant, Gemma, was unsure about her diagnosis and ongoing memory problem. Hence, she sought help from her local GP:

> *I just have half the amount of brain cells. All my cells in the brain are decreasing. I went to see my GP; he was lovely and said, ‘Gemma, let us see what you have upstairs’. My brain, yes, he jokes a lot. He proposed a brain scan to see any problems and how to regain myself. So, I went for a check-up, and later, he said that all my organs were 100% and fine. I am diabetic; might that cause memory loss? Mostly when I am tired, I cannot recall anything. Because I am mentally exhausted by what others say, I say yes, rather than ask it again. I do not want to make them think I am tired. I hope I replied yes to the right thing.*

Gemma self-diagnosed her memory issues as MCI and claimed to have half the brain cells of a healthy or younger person. She sought a medical opinion; her doctor referred her for a brain scan to rule out abnormalities such as fatigue associated with her pre-existing medical condition, which could have contributed to her forgetfulness. However, the results were negative; it is not her brain, but she speculates that diabetes could contribute to her memory problems or mental tiredness. Gemma points out that her "organs were 100% and fine", and her memory problems are an issue of concern. She manages all questions from others by saying "yes" to everyone, lest it may or may not be the correct answer.

Kate also approached a doctor for help in diagnosing her memory problems:

> *I do not see New Zealand doctors because I'm not good at Western medicine. I usually see a Chinese doctor for my health and memory issues. About half a year ago, I asked my doctor if I had dementia. He said that I do not have dementia yet. If I get dementia one day, I don't know what to do because people with dementia do not realize they have it. One thing about it is that the technologies now keep improving. I hope scientists will find medications to enhance memory. I am getting old and do not have a purpose in life, and I am just living day by day.*

Kate worries whether her memory problems are a form of "dementia". For cultural and medical reasons, she prefers to consult a Chinese doctor who reassures her she does "not have dementia yet" but does not rule it out for the future. This made her unsure what to do, as many with this condition do not realize they have it. Technological advances are a comfort for Kate, as she hopes there will be innovations one day to help treat those with memory problems. Even so, she expresses despair and futility because "people with dementia do not know they have it". There is a genuine sense that Kate is upset by the incidences of forgetfulness, and she claims not to live a purposeful life. Memory and a sense of purpose are intertwined.

Similarly, Maya worried about getting dementia someday and contacted her GP for advice:

> *So, of course, I am afraid of getting dementia. That is why I went to see my GP a few days ago and asked him if there was any medicine to help improve my memory so that I do not get worse so fast. He told me there was no medication but to use my brain more. He asked me to exercise, read and play memory games like Mah-jong because you must remember what others took out and know how to keep winning. He reminds me to sing because you must recall the words, which keeps your brain active.*

Maya seeks preventive treatment for her potentially worsening memory and "improve [her] mind". Her doctor indicated no such medication but recommended she "exercise, read and play memory games […and] sing" to keep the mind supple. Seeking medical advice helped her learn ways to improve cognitive function, such as the memory game "Mah-jong". Maya's story conveys that knowing strategies to promote and enhance psychological wellbeing and memory loss is essential to slow the process.

Knowing discomfort

The feeling of discomfort is another issue for people suffering from memory problems. Participants describe how forgetfulness makes them uneasy, prompting them to seek help and reassurance daily. Maya feels uncomfortable when she burns food, and when she goes out, she often forgets trivial things at home:

> *One day, I was cooking something and hurrying to go out. When I went out, I was afraid I did not turn off the oven. Other times, I returned, and it was off when I got home, and I felt nasty because of that. Often, I tell my family about this and how stupid I am, and they laugh. For example, this morning, we celebrated Valentine's Day on the Chinese calendar. Last night I took things out and put them near where I could find them the next day. However, I forgot my bottle of water at home. When I reached the Church and wanted to drink water, I opened my handbag and could find it. It was uncomfortable, but my friends reassured me and said they had the same memory problem.*

Maya conveys concerns when cooking and forgetting "the bottle of water"; both incidents make her feel "uncomfortable". Maya's fears of worsening memory loss are underlined by her automatic second-guessing of her memory, becoming used to mistrusting herself and being disappointed, despite assurances that it is normal. She seems tough on herself when reporting complex, forgetting essential things but finds solace because her friends also have "the same memory problem".

Gemma articulates similar unease when knowing about her memory slowing over time:

> *A few years ago, my memory problems began with my brain slowing down since I came here. I usually take my grandchildren to school now, I do not drive, and walking is slow. Yeah, memory also becomes a blur and fluctuates sometimes. I forget a little more than usual on bad days. When I watch a movie, someone tells me something I do not remember. Well, I struggle with my memory; I dislike being like this.*

Since moving to Aotearoa New Zealand, Gemma has noticed her memory slowing down, and she struggles with daily tasks like dropping her grandchildren off at school. Her memory feels like "a blur" and "fluctuates". She talks about forgetting "a little more than usual on bad days", noting that these problems are not static and can worsen depending on the situation. In her anecdote, she points to discomfort when watching a movie or someone tells her something she "struggle[s]" to remember and does not like forgetting. In the interpretation of "I dislike being like this," Gemma shows her anxiety about living with forgetfulness, which depicts her discomfort when she cannot do things she did previously.

Mary puts great emphasis on knowing about the English language but struggles to do so because of her memory:

> *I am very devoted and want to learn to speak English; I still try to write, but it is hard for me because it is a worry when I cannot remember. My blood pressure went up, so my daughter-in-law asked me to stop. Hence, I stopped learning because it was challenging and uncomfortable.*

Although committed to learning, Mary is concerned that her mental ability to retain information is affected, highlighted by her "blood pressure" escalating when studying. She stopped having lessons at the request of the family. Mary's experience shows a willingness to integrate into New Zealand society by learning English; however, her memory problem seems to be a hindrance.

Tracy conveyed feeling awkward when she forgot to send leftover food home with her children that she had cooked explicitly intended for her grandchildren:

> *Sometimes, I make food for my kids when they visit me. I wanted to ask them to take the food when they went, and then I forgot. Then I felt uncomfortable that day, and the grandchildren did not get a chance to eat the food I made. I made food for the grandchildren but was forgetful and did not ask them to bring home the leftovers. I was telling myself; how could I forget?*

Tracy's story describes a sense of happiness when preparing homemade food and looking forward to the family enjoying it. Tracy feels guilty and "uncomfortable" when she forgets to give them the leftovers when they are leaving. Her story shows the distress caused by memory problems, and she keeps asking herself how she could forget this. Her story demonstrates a sense of self-importance and discomfort attributed to memory problems.

Knowing about dementia

Some participants confirmed their worries about the link between memory problems and the stages of dementia. MCI is not dementia per se, but it can become a serious health problem as about 15% of people with MCI can progress to the early stages of dementia (Jia et al., 2020). Still, several participants expressed concern that it may be the case. MCI is seen as a burden for their families, and they worry about getting dementia based on knowledge gained from various sources and seeing others with dementia.

Susan ignores her apprehension about her worsening memory problems and instead focuses on her fear of going to aged-residential care:

> *Because my children are busy, I will not tell them about my worsening memory problems or burden them. Instead, I talk to other Chinese Association members but not my children. I feel relieved after revealing my memory problem to my friends or nurses. Even though my memory is incorrect, I am excited and would like to express myself and talk. I do not have to write the stuff so I can speak freely and systematically. My son and daughter-in-law are in China; they are busy and cannot support us much. So, if our health worsens, the only thing is to go to a rest home. I am very reluctant, especially with my husband. He is not happy to live in a rest home because that is where my son-in-law's parents are, and when we visit them, we see all the residents with dementia looking so helpless. My husband and I are sad and reluctant to live in a rest home, and we want to continue living in this flat.*

Susan does not want to "burden" her family with her memory problems as they are busy. Instead, she confides in nurses or her friends and feels "relieved" and "excited" because she can talk "freely and systematically" to them. Perhaps her speech is unaffected by her memory problems, not bothering her friends. Susan and her husband share their reluctance and worry about moving to a rest home, as they encountered the helplessness of her in-laws when visiting them. She describes feeling "sad and reluctant" to live among those with dementia in the future and would prefer to stay independently in her apartment.

Anne recognizes her fear of not being able to remember her English lessons, memory deterioration being the main issue, and she worries this could be linked to early dementia:

> *Since last year, I have been learning English, and I forget when my teacher talks about something in class. When I remember five new lessons, I only recall two or three as time goes by. When I go to the kitchen, I forget what I came to look for in the fridge! I forgot again. When cooking too, I forget. Often, I forget the key or the bus card, my money, and my purse. I am genuinely concerned if I have symptoms of, you know, dementia. Is it an early stage of dementia? I also come to the Korean group from the city to do ballet exercises and other activities. I enjoy my life and try to manage my time well. But I am concerned about my future. I am looking for healthy food and other ways to prevent dementia, use my brain more, and do physical exercise.*

Anne's story illustrates her concerns about "recall[ing]" her English lessons; she admits to remembering only two or three points. Opening the refrigerator, she "forget[s] what she came to look for". She recounts other incidents, such as forgetting the house key, bus card, money or purse. There is a sense of disappointment; as time passes, she fears getting dementia. In her quest to prevent this, Anne eats "healthy food", believing she must keep her brain supple and body active in physical exercise. The activities at her community centre support her and promote the importance of strengthening her mind and body.

Knowing about dementia worries Charles too:

> *I can assure you, dementia, God! It frightens the hell out of me. I do not think I'm there yet because I just asked what it leads to. As I said, my wife has been a nurse for so long that I have seen and heard many things, and I hate forgetting things. When talking about memory loss and dementia, what does it do to people? You do not recognize things or people and need care. I can guarantee you my body looks 66, but I am 20, man! I do not want to burden anyone because of a memory problem. The joy of life has disappeared. I am a person who loves life, dancing, excellent beer, a good laugh, and a lot of good friends, and I love good movies. I like to discuss the news, whether in America or South Africa. But when you are losing all that, why are you living then? You forget what you ate and do not know whom you are talking to. Personally, that is the frightening aspect. I do not want to lose my independence, mate. Oh goodness, I must be honest; that scares me terribly.*

Charles reveals how the word dementia "frightens the hell out of [him]", referring to his uneasiness experiencing memory problems. Charles knows much about dementia and its impact on people's lives when they "do not recognize things or people and need care". He seems concerned he could be like that someday, and, in his view, his body "looks 66", but he feels like a 20-year-old. Charles states he still has the intellectual ability to discuss the news and has an active brain—far from getting dementia. Charles enjoys his way of life; dancing, watching a good movie, drinking an excellent beer, and laughing with his friends. He infers dementia would mean the end of these activities by taking away his "joy" and "independence". He is anxious not "to burden anyone" if he ever gets dementia, "Oh, goodness, I must be honest, that scares me terribly." Charles does not yet have dementia but knowing about the possibility of getting it worries him.

Eileen's story illustrates knowing of family connections to dementia and being apprehensive she could get it someday:

> *I am worried about getting dementia. Sometimes I read books to find out more about preventing dementia. Now my sister-in-law had dementia when she was only 55. In five years, her memory slowly worsened until she suffered from dementia. In the end, she died at an early age, around 60.*

Though Eileen does not have dementia, she reads about how to prevent it. She explains the gradual progression of her sister-in-law's early-onset dementia and subsequent death. Eileen conveys a sense of unease, fearing that she similarly has memory problems and could follow the same path.

Catherine's concerns are about genetic links to MCI, which she thinks can lead to dementia:

> *I have memory problems and ask my family if it is genetically related. I heard that if you have memory failure, you get dementia. My family said it depends, but that is not always the case. I have a brother in his 80s with dementia, which is worrisome.*

Although Catherine did not get a specific answer from her family about the genetic link, she worries that since her brother has dementia, she risks getting it too. Catherine is understandably disturbed that memory problems are early warning signs of dementia. She makes the connection based on her brother's history.

Joan is concerned that her memory will worsen too, and she will risk losing her cognitive abilities, but she hopes there will be a cure soon:

> *In Korea, people live about 85 years old, which is a long life. Previously, it was only 60, rarely 70 or 80, but in the past, everyone died at about 60. They all had excellent memories before they died. It is a big problem, and the life span is much longer. They live up to 80 years old or even 100, but physically they are fine. But mentally, they are not so good. I hope scientists find a cure for those with memory problems or the right medicines to help people get a memory problem one day. Some people with dementia or Alzheimer's live in large hospitals in Korea, just like my mother. They have long-lived, but they have significant memory problems as well. I am worried because I have a similar memory problem to my mother.*

Joan mentions that people in her home country have long lives but experience memory problems. She tells of Koreans previously living till their 60s. However, due to longevity, life expectancy is near the 80s, and some live to 100 years old. Joan shares that everyone used to have "excellent memories before they died", which poses a social problem. People live longer lives but are "mentally" unwell. Joan hopes there will be a "cure for those with memory problems," allowing them to enjoy life one day. Joan worries about the future because of what they see in the present. She tells her mother, who had dementia before, and Joan worries she might end up in the same situation one day, reflecting that her memory problems can lead to dementia.

Knowing positive approaches

The participants, afraid of their memory problems, embrace positive activities that enhance their memory and wellbeing. For example, reminiscence is a positive and rewarding way to look at past events and activities (Moon & Park, 2020). Similarly, embracing diversional activities involving memory or re-enacting pleasant moments is helpful for participants. When participants remember these enjoyable times, it brings positive emotions and helps with memory complications.

Mary, a member of the community association, speaks of how positive attitudes help memory decline:

> *So, it would help if you had a positive attitude. I have found that if you forget, then it is not correct. As for me, I come to this community association, and I meet friends. I keep myself busy, cooking meals for my family, and I love singing and dancing. These keep me happy, and I keep myself going, which helps with my memory. I realized I need a positive attitude, so I am glad about what I do. When I come to this Chinese Association, sometimes I bring food to the members. I am so happy when I see them enjoying my food. These attitudes help me with my memory problem when they are so delighted. When I first came here, I was not that happy. Sometimes when I overthink, I start to cry. So, I keep myself busy, and my memory does not seem to worsen when I'm at ease in my life.*

Mary's story reminds us that a "positive attitude" is vital for well-being. She says being forgetful is "not correct"; she is unhappy when she forgets something. Singing, dancing, and taking home-cooked food to her friends at the association "keep [s her] happy", especially when she sees them appreciating the food. These activities generate a "positive attitude" that improves her memory. Mary referred to her previous discontentment and ill health when she arrived in this country. She mentions overthinking things that make her emotional (her depression is referred to in an earlier story). Mary implies that attending the Chinese Association has provided inner happiness that helped her emotional problem and memory.

Gemma remembers the optimism of good days when her memory was better and described techniques for improving her memory:

> *Before, my mind was quite sharp. Sharper and brighter than my two girls, and it was good. I would ask them to be positive, calm, peaceful, and focused on themselves. Focus on what you are saying and thinking, get up in the morning, and do some meditation that helps me. Meditation helps me a lot, with fresh air and exercise. Is there any exercise to regain it? Write down the present and then recall and see what you did. I think that will help my memory. I enjoy playing a few memory games, Sudoku or similar ones. I like to read, but now I must read many times to get it. I try to remember what I did yesterday, like practice. I think recalling last night's event and writing it down would help. I also try to remember the previous day's incident to sharpen my memory. Yes, it helps.*

Gemma tells how her memory used to be “sharper and brighter” than her daughter's. Her suggested strategy for them in life was to be “positive, calm, peaceful, and focused” on what they say or think as it improves brain function. Gemma enjoys keeping her mind active by meditating, reading, getting fresh air, exercising, and playing “memory games”. Sadly, she tells of not remembering what she has read; she must “read many times” and needs information written down to retain it. Her story conveys the positivity of engaging in enjoyable activities that help improve cognitive health.

Remembering positive memories can help build resilience when someone has memory problems. Eileen, by comparison, depicts having trouble recalling such moments:

> *Sometimes I cannot remember lovely memories but, as you know, there is a Chinese saying: We do not think about the past since it has gone already. You do not have to call back a good day; keep going. We need to inspire ourselves to use our brains more; if we do not use our brains, memory worsens quickly. If I write essential things down or read a book, I can sleep better that night. If I use my brain more, I can sleep well. Otherwise, is it to take my anxiety or pressure when writing things down. We need to train our brains more in writing, Tai Chi and daily morning exercise. I find these therapeutic as it helps me.*

Eileen has trouble recalling the “lovely memories” of the past. She refers to an old Chinese saying advising not to dwell in the past. Eileen does not believe old memories would solve her problems; she must move on in life. Her anecdote does not necessarily relate to forgetting wonderful experiences but avoiding making mistakes and slip-ups. Eileen argues she needs to use her brain more or risk a deterioration in her memory. To ensure that does not happen, she writes important things down or reads a book to help tackle her “anxiety” and encourage her to “sleep well”. She speculates “writing, Tai Chi and daily morning exercise” as positive strategies to improve her memory. There is a sense of the therapeutic value of these activities that will enhance physical health and memory.

According to Charles, knowing about positive attitudes leads to positive emotional well-being:

> *I’m merely philosophical. Positive attitudes bring good days to my situation. When you are negative, you are down a man. You tell yourself what is right and what is not good. I celebrate bad and good because they weigh each other; if you balance them, we have gotten better than bad. If you are not positive or do not continue training your mind or give yourself a goal or something to focus on, your mind will wander. Becoming negative will affect my brain, which I take as memory degeneration. It is going backwards and results in many other ailments that come along. If something comes to mind, which is wrong, it changes your focus. I tell you to occupy yourself, look at a tree, plant, or fish, and change your mind. I know I am slower and forgetful, and I agree that is inevitable. But I try to slow down this mental process by doing other things that bring pleasant thoughts. If you put garbage in your brain, it gives you garbage; it is like a computer. I believe that is just my little philosophy.*

Charles articulates his “philosophical” attitude; being positive makes him happy. He tells of someone with negative thoughts that can convince themselves they are, in fact, positive ones, which is in itself a form of pessimism. Charles tells of celebrating “bad and good” because they “weigh each other”; perhaps good deeds will outweigh foul over time. He believes that if someone does not keep “training [their] mind”, has no goal in life or has nothing to focus on, their “mind will wonder”, which affects their memory. Positivity in life brings Charles inner happiness, while negativity affects his cognition and is a backward step leading to health problems. His ways of dealing with negative attitudes are to fill his mind with pleasant thoughts and moments; he accepts the “inevitable” truth that his memory is slowing down. Charles likens the human brain to a computer and believes that putting evil thoughts into one’s head will negatively affect it. In the interpretation, these beliefs relate to the concept of ‘garbage in, garbage out’ (GIGO), a popular notion in the early days of computing, implying that incorrect information fed into a computer can produce nonsense. Similarly, Charles’s knowledge of stimulating the mind improves his emotional wellbeing.

Knowing helpful strategies

Participants’ anecdotes reveal practical approaches to help manage memory problems and stimulate the brain. Methods mentioned include using electronic devices such as cell phone diaries to remind them of daily activities.

Joan uses the diary application on her cell phone as a helpful tool to handle her appointments because she cannot remember them:

> *Before, I used to help my grandchildren with their homework and everything else. I loved to help after school, so I studied with them. Back then, my memory was not an issue at all. But now I must use a diary. My diary is on a smart mobile phone, and I put everything on it. However, with too many memos in that diary, I now find it difficult.*

Joan previously helped her grandchildren with their homework and claims her memory was good then, but she conveys her inability to do the same now because of her memory problems. It seems studying together with the grandchildren is an excellent way to keep her mind active. Joan uses the diary function on a “smart mobile phone” to record notes and schedules. However, now she finds it hard to handle because it is too full of “memos”. Interestingly, her daily planning method uses cell phone technology and does not rely on human memory.

Eileen remembers routine things by writing them in a diary or the calendar on the wall:

> *The problem is that I need to write it down in my diary and then put it somewhere to remind myself. For example, I am writing what I must discuss in the group today. I must commend seven association members who have left and appreciate their contribution. If I do not write it down, I have only prized five or six and left one or two. It does not matter for a while because I tell them later, oh; I have forgotten. Another thing is that I must open the door with a code number, so I write it in my diary. To avoid relying upon my memory, I help by memory writing on the wall calendar or in my diary.*

Eileen’s diary and wall calendar are constant reminders to recall specific information for her group and door lock code. However, she has trouble remembering where she puts her journal because of her forgetfulness. If Eileen does not write down the names of people, she will forget at least one or two. She wants to avoid relying on her memory, so she strategizes by writing important information in her diary; however, this can prove unreliable if she mislays it.

When Charles needs to remember something important, he finds his “memory book” (diary) helpful:

> *Sometimes I note what to do in a memory book if I slip up for no concrete reason. I put together a list and ticked it off when I had done it. But when you have five things to do, and if you don’t write them down, I can assure you I will recall three out of every five. I can show you my memory book many years later, which I account for. It is merely a habit. Because of the memory problem, that stuff goes haywire, and you overspend. It is a problem. Stress is my main trigger, and everything can slip my mind; it is scary. That is why I must write it down.*

Charles lists what activity or valuable information he needs daily in his memory book to remember it fast; otherwise, he fears his memory will go “haywire”. Charles uses his “memory book” to remind him of important things, which he ticks off when completed. Charles admits to “recall three out of every five” something if he did not write them down. His actions indicate a systematic way of dealing with the issue and avoiding such adverse consequences as overspending. His memory problems seem to stem from stress, becoming scary for him when certain things slip his mind. This memory book is a valuable tool because he must account for everything. The purpose of the diary is a known strategy, crucial in helping his forgetfulness. Writing essential things down acts as a safeguard and brings a sense of purpose to his well-being.

A typical helpful strategy is to take natural herbal supplements to boost memory, as in Joan’s story:

> *Since my memory problems began, I cannot recall everything. I self-manage this myself privately and use St John’s Wort. It is an emergency [laugh], yes. I think it is $50 a month I spend on this. I have searched for curcumin roots and a few other herbals as well. I take these to keep my memory in safe hands. If you have no red meat, you must keep your body alkaline and ph levels at 7.2 or something like that. Many vegetables and fruits alkalize your body, and red meat makes your body acidic. A dairy product is tasty but not good for your body. Eating fewer dairy products, less meat, and more vegetables is good for memory. It is a small thing, but it is essential for me.*

Since her memory problems began, Joan has used herbal products such as “St John’s Wort” and “curcumin” to “keep [her] memory in safe hands” and improve it. She jokes about these as an “emergency” measure, not to save lives but to keep the memory supple, drawing upon her background as a pharmacist to justify her use. Joan also believes that maintaining the proper pH level is crucial; she avoids “red meat” and “dairy products” and must eat lots of “vegetables and fruits” which are alkaline; this strategy of employing her knowledge of herbal supplements and natural treatment is essential for improving her memory.

Reflection

The notion of “knowing” strategies is a common phenomenon regarding how older migrants make sense of their memory problems. van Manen (2014) put forward the idea that “noncognitive knowing is like a nonconscious consciousness that seems to reside and operate directly in and through our body” (p. 48). This quote establishes a biological fact that the brain is part of the whole human body and directly or indirectly affects each aspect of the body. Knowing how to make sense of memory problems interferes with how the participants share their daily life experiences. The feelings and experience of memory problems are complex issues facing older migrants. Strategizing ways to manage memory problems or enhance cognition is highlighted in the subsequent notions: “knowing how it happened”, “knowing about discomfort” of day-to-day experiences, “knowing about getting dementia”, “knowing positive approaches”, and “knowing helpful strategies”.

“Knowing how it happened” portrays how the participants make sense of when their memory problem started or once they first noticed something was wrong. van Manen (2014) pointed out that phenomenology “does not study the “what” of our “experience” but what constitutes the experience of the “intentional object, thing, entity, the event” as it appears in the consciousness (p. 91). In this phenomenological study, the participants reveal known and unknown experiences since they first learnt of the onset of memory problems and what they did about this phenomenon. To understand the notion of knowing, Heidegger’s (1962/2008) description of phenomenology refers to this as “to let that be seen from itself in the very way it shows itself” (p. 58). Heidegger suggests that people understand or ‘know’ their experience by deciphering it themselves. Participants did just that and also sought clarity from a medical professional. The researcher interprets those experiences and provides an ongoing dialogue about how the participants make sense of the event (van Manen, 2014).

Heidegger’s (1962/2008) phenomenological interpretation is essential to know what makes sense in the “Being-in-the-world” of someone with MCI. Heidegger’s philosophy is more existential and consistent with the basic concept of hermeneutic phenomenology. In this study, participants disclose valuable information on how they have learned about MCI through their lived experiences. Recognizing the integration of “knowing and understanding” is about merging this concept of lived experience (Stegeman et al., 2013, p. 599). Understanding how older migrants adapt to unique challenges of memory problems shows how and what they have learned through these life experiences.

In order to understand the phenomenological concept of participants’ lived experiences, it is essential to delve deep into the experience to know how it happened, which Heidegger

(1062/2008) calls "Verstehen"[9]. The aim is not to explain the aetiologies of MCI experience but to understand verstehen is lived experience. That is, to enter or sink into the phenomenon as it is lived (Aho, 2022). This perspective is critical to shed light on participants' experiences and understand how they understand MCI. Heidegger's approach focuses on interpreting these experiences and emphasizing verstehen. To better understand living with MCI, the participants' stories reveal what Heidegger explains about mood and emotion. In this study, participants such as Gemma, Kate and Maya try to understand 'how it all happened' and seek medical opinion (verstehen) about this phenomenon.

'Knowing the discomfort' of what participants experienced when they discovered they had a memory problem is imperative. Heidegger (1962/2008) posits such phenomenological concept as an existing harmony of knowledge in the fundamental ideas of "Attunement" or "Befindlichkeit"[10] (p. 130). Befindlichkeit is another translation of attunement in the Heideggerian perception of interpretation, that is, "how we sense ourselves" (Heidegger, 1962/2008, p. 130). Befindlichkeit is one of Heidegger's three basic parameters of human existence, which are involved in most of his other conceptions. Heidegger's notion of "attunement" refers to the existence of 'mood'. This study is about interpreting the phenomena of MCI through the lens of the individual's lived experience (Todres & Galvin, 2010). Likewise, phenomenologically the participants make sense of a diagnosis of MCI and try to understand how their 'mood' is affected by the notion of attunement (Cowles, 2017).

Participants view "Knowing about discomfort" as revealing their discomfort with memory problems, manifesting uneasiness when they cannot remember daily things. It prompts them to seek assurance or comfort from essential others to understand their condition better. In recognizing these discomforts, participants expressed concern about getting dementia in the future if their forgetfulness worsens (Heidegger, 1962/2008). The participants' stories again show discomfort and angst in describing their experiences, which are beyond their control. Heidegger's description of such existential analysis defines the concept of Befindlichkeit connected with angst.

Moreover, Heidegger describes the concept of "Unheimlichkeit"[11], another phenomenological stance of making sense of an uncanny situation (p. 182). Heidegger describes that being human is inherently uncanny and shows that we can only be who we are if we do not

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[9] Heidegger (1962/2008) use the term "Verstehen" and "Attunement" to explain Being and Time as being counter intuitive. His interpretation of Verstehen seems to be closer to what is commonly designated, understood or how it happened.

[10] Befindlichkeit stresses the primary state of Dasein in how it is being situated, that is "being there"; or finding ourselves already in a similar situation (Oxford Online, 2019).

[11] Unheimlichkeit is another German word of Heidegger (1962/2008) to describe being peculiar. He uses this term to demonstrate being "not-being-at-home", which is a further suggestion of being in an uncanny experience.

understand what the being is. Maya, Mary, and Charles' stories show discomfort experiences by making make sense of the uncanny experiences.

Participants expressed their fear of what memory problems would mean for them, perceiving warning signs as early 'dementia'. Concerning such fear, Heidegger (1962/2008) points to knowledge of "peculiar difficulties rooted in mode" (p. 16). Moreover, van Manen (2014) interprets it as speculating how things might develop. I understand these stories as depictions of anticipation and fear of the eventuality of getting dementia. There is a sense of "uncanny" feelings that reveal themselves in participants' worlds. Heidegger's notion of angst depicts the fear of dementia as a fundamental mood. Dasein is about participants making sense of their anxieties: "careful to distort this angst into the fear of future events" (van Manen, p. 235). Fear of dementia shows the nature of dasein in this world, which sounds peculiar to participants as they explore what is happening to their memory. Some of these concerns relate to being burdensome to family members, fear of needing more care and support, concerns about dementia, and loss of daily cognitive abilities.

Reflecting on the concept of "knowing positive approaches" depicts a sense of happiness when participants are reminiscent of pleasant moments in their lives. Living with memory problems can be a frightening experience for participants, but enjoyable moments with family and friends are perceived as good for their memory. Being reminiscent of pleasurable moments can help people recall their previous experiences, add meaning to their lives, and improve cognitive function and quality of life (Moon & Park, 2020). In accord with Heidegger (1962/2008), the world of dasein is conjectured in this situation as "Mitsein", signifying "Being-with-others" and "Being-in-the-world" (p. 41). Ontologically speaking, "Being-in-the-world" and "Being-with-others" involve experiencing positivity by engaging with friends and relatives in everyday events. Knowing and recalling such positive emotions brings happiness.

The last notion outlines participants' 'knowing helpful strategies' to relieve their discomfort and embarrassment of suffering memory problems. This study shows the importance of daily activities and routine physical and mental exercise to support the person in managing MCI. A feeling of happiness is gained from such actions, which are mostly taken for granted by participants (Clarke &Warren, 2007). The stories of Joan, Eileen and Charles highlight the specific tools or strategies they use to remind themselves and manage their memory problems, such as notebooks, diaries and cell phones app. On this matter, van Manen (2014) talks about the significance of knowing organic material and the technological world and understanding how to manage our lives. van Manen says, "phenomenology is about wonder, words, and the world" (p. 13).

Summary

The quintessence of this chapter concerns forgetfulness and knowing how to make sense of MCI. Different strategies for managing forgetfulness are stressed, reflecting the theoretical interpretation. The participants shared how these strategies support them in their daily lives: knowing how memory loss happened, underpinning their discomfort or uneasiness, knowing their fear that memory problems could signal dementia, and knowing positive attitudes to prevent memory worsening. When older migrants experience forgetfulness, many find some practical tactics to make sense of their surroundings and improve their mental welfare. In my philosophical interpretation of understanding forgetfulness, I referred to some of Heidegger's (1962/2008) concepts of "Verstehen", "Attunement", "Befindlichkeit" and "Unheimlichkeit", "Being-with", and "Uncanniness" "Being peculiar" in the context of "Being-in-the-world" of an older migrant with MCI.

This chapter is the last of the four findings. The next chapter summarizes and discusses the most important findings of older migrants living with MCI. I will outline the impact on clinical practice, education, policy, legal standards, and research results. I display personal learning and reflection upon this study's phenomenological position, strengths, and limitations, ending with a closing argument.

Chapter Eight: Discussion

We do not remember days; we remember moments. The richness of life lies in memories we have forgotten.

Pavese Cesare: The Burning Brand (1935-1950)

This chapter marks the end of a fresh beginning in discovering the lived experience of older migrants with MCI. Pavese Cesare's words, quoted in the epigraph above, relate to remembering when happy moments remain while memory has become problematic. This notion reverberates well with older migrants' stories which underline their memory problems. MCI among ageing migrants is a widespread phenomenon affecting older populations globally (Davies et al., 2010; Xu et al., 2018). Research on MCI within this group is scant (Bampa et al., 2017), specifically research using phenomenology as a methodology. This study promotes a better understanding of 'the lived experience of older migrants with MCI'. It is imperative to reflect on how MCI has added meaning for senior migrants because of the physical, psychological, social and cultural aspects of ageing in a foreign land (Lu et al., 2021). The findings reflect the richness of phenomenological data that reveals the actual lived experience of participants.

In this chapter, I detail a summary of the four main findings. I then examine the methodological relevance by exploring and comparing the latest empirical and conceptual ideas regarding MCI and its importance to older migrants. I present the implications to practice, education and subsequent research and how the findings are essential for shaping policies for older migrants. I also offer the study's strengths and limitations, explain the original contribution of this study and present my closing remarks.

Key findings

This study reveals how MCI plays a prominent role in older migrants' lives. The phenomenological notions and experiences of 15 older migrants with memory problems are highlighted. Against this unique philosophical backdrop, Heidegger (1971/2001) indicates that we "never come to thoughts, rather they come to us" (p. 6). Thus, participants' stories are exposed when they first notice that their memory has started changing slightly. Being forgetful is a common phenomenon they face, with some experiencing adverse consequences.

The richness of the data for the existing research on MCI and the phenomenological idea of lived experiences of older migrants are recognised here (Beard & Neary, 2013; Bray et al., 2018; Lu et al., 2021; Rose, 2017; van Wijngaarden et al., 2019; Xu et al., 2018). The current study employs Heidegger's existential and philosophical insight to highlight the phenomenon of MCI and illustrates what can be hidden from the individual (Alves et al., 2018). Heidegger's (1962/2008) notion of 'hidden' refers to someone being so closely affected that they cannot understand or perceive what is happening to them. At the same time, stories of individuals with MCI depict how they notice memory loss plays a vital role in their daily lives and how they experience this condition.

The research question addressed ‘what is the lived experience of older migrants with MCI’? Hence, this study highlights the distinctiveness of phenomenological knowledge concerning the voices of older migrants experiencing MCI. I have discussed the fundamental concepts of MCI earlier, which explain its attribution of physical, emotional, psychological, social and intellectual problems affecting older migrants. Heidegger’s (1962/2008) notion of “Being thrown” confirms that as human beings, we are “thrown” into a particular situation that we have no control over, yet we have learned to cope with it. “Being thrown” into distressing situations contributes to participants’ experiencing memory problems over time. Regrettably, it conveys another critical message concerning shame, disappointments, and stigma of having MCI. Participants affected by MCI demonstrated how they employed the tactical means of self-coping or self-help to circumvent social isolation and relieve their memory problems. Connecting with others and knowing how to make sense of MCI are suggested coping strategies. These ideas are presented in detail through a complete description combining quotes from participants’ narratives and hermeneutic interpretations.

I discussed the impact of MCI on older migrants as they are challenged in their daily lives because of being forgetful. The cultural and ethnic backgrounds of those with MCI are essential considerations too for stakeholders involved in the health of older migrants (Beller et al., 2017; Palmer, 2016). It is also crucial for health professionals to ponder that when migrating to a new country, linguistic and acculturation issues can severely impact migrants’ memory following prolonged periods of stress (Buja et al., 2013; LeMaster et al., 2018; Xu et al., 2018). Added sufferings are comorbidity and possible death when their physical health deteriorates (Bray et al., 2018). Besides physical and psychological health complications and sociocultural considerations, MCI is linked to the negative experiences of older migrants after resettlement (MSD, 2018; Ramsay et al., 2017; Wright-St Clair et al., 2017).

By underlying the participants’ experiences, this study aims to bridge a gap in existing knowledge and for stakeholders to learn more about MCI. This thesis mentions the hypothesis of an ABC model; Antecedent (someone is “Being thrown”), Behaviour (“Being with” and behavioural impact), and the Consequences of MCI (being in the world and making common sense). This approach guides us in knowing more about the exceptionality of experiences faced by older migrants with MCI in Aotearoa, New Zealand. In the next sections, several sub-notions are analysed based on the main findings of this study.

Being thrown

According to Heidegger (1962/2008), humans are “thrown” into the world, meaning they find themselves in a pre-existing reality without their choice or control. Humans are born into a particular time, place, culture, and historical moment and must confront the world as it presents itself. The first notion shows being thrown as a significant harrowing experience for participants. Being thrown shows how stressful events such as family trauma, retirement, acculturation, no longer being able to drive, and health complications can affect memory. The notion of thrownness points to the "mood" of older migrants when such events impinge upon their "Being in the world" (Heidegger 1962/2008). Participants hurled into these distressing situations show that dasein touches upon their lives, contributing to MCI. The concept of thrownness is a fundamental aspect of Heidegger's philosophy, as it emphasises the significance of understanding the historical and cultural context in which we exist. Heidegger argues that we must become aware of our thrownness and confront it to understand our existence and relationship to the world around us. In essence, thrownness suggests that our existence is not a matter of our choosing but rather a fundamental condition of our "Being in the world".

Harrowing experiences, family events, or challenging situations may contribute to psychological problems and subsequently affect memory (Lam et al., 2015; Livingston et al., 2020). In response to these experiences, the brain can release stress hormones impacting memory, which in some cases, the brain may suppress or alter memories of the harrowing event as a coping mechanism, leading to memory loss (Hannibal & Bishop, 2014). This phenomenon is often termed dissociative amnesia, another form of MCI. Phenomenologically, dasein is about being thrown into such existence, which Heidegger (1962/2008) explained as 'projecting' in the world. Based on this perception, moving to a new country is seen as a harrowing experience that can ultimately affect psychological well-being and memory (Bray et al., 2018). Older migrants find themselves somewhere, namely, a world they are influenced by and by being with others (Critchley, 2009). Participants experienced grief when being in those harrowing situations, revealing frightening, traumatic and disturbing being of dasein, which is reflected in the appearance of "Being-in-the-world" (Heidegger, 1962/2008).

Participants' stories demonstrated being thrown into a state of unpleasantness, self-directed sentiments of disappointment and embarrassment, and memory difficulties. Health problems, acculturation, socio-cultural beliefs, and social isolation were significant predicaments that contributed to MCI. Other studies have shown how older migrants are prone to cognitive issues when exposed to specific risk factors, such as traumatic events (Mavrodaris et al., 2013; Parlevliet et al., 2016; Wang et al., 2019). A similar association with MCI highlighted dissociative memory loss when people were exposed to psychological ill-health, leading to forgetfulness if prolonged over extended periods (American Psychological Association, 2018). Further evidence also favours a predictive or causal role for memory problems after exposure to a significant stressful situation (Brewin, 2011). In essence, thrownness suggests that our existence is not a matter of our choosing but rather a fundamental condition of our being in the world (Heidegger, 1962/2008).

Being unwell

Being physically and psychologically unwell is a well-known problem affecting seniors. From a phenomenological perspective, anxiety was one focus of being sick, "anxiety from the kindred phenomenon of fear" (Heidegger, 1962/2008, p. 227). Tangney et al. (2007) describe how self-awareness plays an essential role in understanding anxiety and detail the conceptual model of "self-conscious". It should be noted that the human body is well-equipped to cope with a certain level of discomfort and cope with anxiety. However, this study shows that participants' memory was significantly affected when being unwell. Other studies assert the link between physical health issues, ageing and increased vulnerability to immune function and cognitive performance among older people (Klimova & Dostalova, 2020; Segerstrom & Miller, 2004). Physical health issues are common among ageing individuals. The human body goes through various changes and may become more susceptible to illness and disease as we age, which can impact cognitive function, resulting in memory loss, difficulty concentrating, and other changes that can impact daily life.

Studies have also described how continuous physical activity and many types of social and cultural engagement are vital to enhancing cognition (Klimova & Dostalova, 2020; Moon & Park, 2020; NIA, 2017). This study demonstrated how regular physical and mental exercise is vital for some participants to reduce the risk of, or slowing down, the development of cognitive problems. Common symptoms of memory problems were sleep deprivation, hearing loss, physical illness such as shingles, cardiovascular issues, depression, and additional morbidity factors (Hussin et al., 2019). This study reports that reducing these common symptoms is a valuable strategy for these participants with MCI to improve symptoms and evoke positive emotions and memory. The following section elaborates on acculturing, another harrowing experience for older migrants.

Acculturing

Acculturation can occur in various settings, such as when an individual migrates to a new country or when two distinct cultures come into contact within the same geographic region (WHO, 2020a). A range of factors, including the relative status of the cultures in contact, the level of connection between cultures, and the degree of acceptance or resistance to cultural change, can influence the acculturation process. Despite acculturation contributing to positive and negative effects, exposure to new ideas and practices can broaden individuals' perspectives, leading to increased cultural awareness and understanding. On the other hand, acculturation can also lead to marginalisation, disorientation or loss of cultural identity, particularly for older migrants when forced to assimilate into an unfamiliar culture (Ng et al., 2017).

This study confirms the effect of anxiety faced during acculturation to an unfamiliar country. Phenomenologically, individuals are 'thrown into existence', suggesting a moment of recognising what happened when they migrated to a foreign country (Heidegger, 1962/2008; Xu et al., 2017). The issue of acculturation resonates well with the notion of angst, moving and adapting and showing how cultural heritage and identity affect memory (Kim et al., 2015). The acculturation context is consistent with the study of Hwang and Ting (2008), suggesting that older migrants face adaptative challenges due to gaps between their cultural principles and that of their host country. Older migrants may struggle to accept the cultural values of the host country, which can harm their psychological well-being and lead to memory problems (Beller et al., 2017; Klimova & Dostalova, 2020). It is assumed that older people may feel more alienated when they migrate to individualistic societies and experience adjustment and engagement issues that affect psychological well-being (Beard & Neary, 2013; Bhugra, 2004; Ramsay et al., 2017).

Moreover, Henderson’s (2019) study found that psychological problems such as cognitive decline can lead to MCI. Similarly, this study confirms that a sense of loss and fear of the unknown affects older migrants’ psychological health upon moving to an unfamiliar country. Findings point to some participants struggling with familiarizing themselves and adjusting to life in Aotearoa New Zealand. Their memory problems attributed to the stresses of migration are noticeable in the participants’ stories. Some have trouble recalling names and places and remembering familiar tasks such as cooking and other routine activities. Others experienced feeling sad, unhappy, stressed and having lasting memory issues when doing daily activities. Phenomenologically, in the wake of ‘being thrown’, memory problems are revealed.

Being alone

Heidegger’s (1962/2008) philosophy emphasizes the experience of “Being-in-the-world” and the fundamental importance of human relationships. Heidegger argues that humans are fundamentally social beings and that our interactions with others shape our sense of self. Heidegger conveys that the experience of loneliness arises when we feel disconnected from this fundamental sense of being-in-the-world, and we feel isolated from others. Being with others is perceived as connecting with others and demonstrating belonging to a particular person or group. However, according to Heidegger, the experience of loneliness can be particularly acute in modern society, where individuals may feel disconnected from traditional social structures and institutions, leading to a sense of aloneness (Van Orden et al., 2020).

Literature addressing aloneness points to decreased social participation and notable social isolation in older people is posited as a contributing factor globally to adverse mental health problems (Courtin & Knapp, 2017; Jamieson et al., 2018; Mushtaq et al., 2014; Van Orden et al., 2020). Specifically, studies show a significant positive correlation between social isolation, loneliness, and cognitive difficulties among older people (Canevelli et al., 2020; Van Orden et al., 2020; DiNapoli et al., 2013). On the other hand, Luchetti et al.’s (2020) study expanded the notion of loneliness and the risk of cognitive problems among older migrants by suggesting that increasing social connection help with mental stimulation.

Interestingly, being lonely is one of the modifiable factors that can prevent serious memory problems (Qiu et al., 2009). This study supports findings that social connection and stimulation improve low cognitive functions among older people. In fighting loneliness, interventions like social activities and being socially connected benefit a more senior individual (Kim et al., 2015; Lara et al., 2019). However, Shankar et al. (2013) disagree and suggest that interventions promoting social connections only benefit some people with low education levels because many are socially isolated. On the contrary, the participants of this study came from mixed and diverse socio-cultural and educational backgrounds, and they all advocated mentally challenging activities to keep the mind stimulated and reduce social isolation. For example, family activities, attending a place of worship, and community organisations are supposed to reduce social isolation, improve social ties, and benefits memory (Nikmat et al., 2015; Wilks & Croom, 2008).

Participants' stories point to the thrownness associated with an extended period of aloneness. Being thrown into isolation illustrates a painful psychological experience, leading to severe morbidity over time (Xu et al., 2017). Participants mention facing sadness, distress and disconnection from society. A snapshot of the stories reveals family circumstances, losing close relatives, ill-health of partners and adjustment to sadness contributing to loneliness. Despite this negativity, participants found solace in spending time with family, friends, and fellow members of cultural or community associations.

Living with MCI

Building stronger and broader social ties can increase feelings of happiness and self-worth. Participants in this study described ways they enhance social comfort and keep their memory supple by connecting with others. Regarding living with MCI, the following notions are identified: connecting with others; understanding cultural values; diagnosing MCI and fears and incorporating mind-stimulating activities.

Forgetting of being

Heidegger's (1862/2008) notion of: "forgetting of being" is closely related to the term "Seinsvergessenheit",[12] or the 'abandonment of being'. For Heidegger, Seinsvergessenheit is described as what Heidegger sees as general forgetfulness or neglect of being. Heidegger contends that in modern society, people focus on technology, progress, and efficiency and have lost sight of the more profound meaning and significance of existence. Bearing in mind that the mystery or secret of being is the "ontological difference" between existence and some particular revelation of a world and the conditions that make it possible (Bartky, 2008). Heidegger refers to the negativity in the modern world that stems from being forgetful. It is no longer a human failure but is based on the retreat of "Being" itself. Heidegger (1962/2008) refers to forgetfulness, or the act of forgotteness, has led to a range of problems in modern society, including a lack of purpose or direction, a sense of and a sense of disconnection. Heidegger suggests that by becoming more attuned to the more profound meaning and significance of existence, one can reconnect with their fundamental sense of being-in-the-world and gain a deeper understanding of themselves and their place in the world.

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[12] Seinsvergessenheit is interpreted as the existence of our failure to recognize, respond to, and experience an appreciation for being the one that grants us a place in a world of entities (Bartky, 2008).

Literature on forgetfulness is associated with social isolation and the current signs and symptoms of a neurodegenerative disorder or specific age-related diseases (Chen et al., 2017; Ivanchak et al., 2012; Winblad et al., 2004). Other studies show similar findings, reporting that forgetfulness in the social context and subsequent physical health impact psychological problems (Cacioppo et al., 2013; Van Orden et al., 2020). Managing forgetfulness by doing meaningful activities, committing to sharing culture and developing a sense of cultural identity are all vital for older migrants (Kim et al., 2015; Tang et al., 2018).

Typical findings associated with older migrants include forgetting daily tasks, losing insight and the ability to do skills, changing roles, and being concerned about burdening their families. Findings also show participants forgetting groceries in the shop and going without food to avoid the shame of returning to the shop to retrieve it. Others misplaced or forgot the house key and money and expressed embarrassment at being locked outside their homes, waiting to be let in. Some underwent the awkwardness of burning food when they forgot to turn off the oven. These findings show the effect MCI can have on older migrants (and potentially other seniors with MCI). There is a trend in these findings to suggest that everyone is vulnerable if they have MCI. This vulnerability is influenced by cultural diversity, psych-social health, physical health issues, social isolation, reduced care and support from essential family members, and lack of understanding of Aotearoa, New Zealand's health systems.

Connecting

In “Being and Time”, Heidegger (1962/2008, p. 97) describes the notion of how ‘forgetting of being’ (also being abandoned) is a central concept of his philosophy. He argues that in the modern age, one has forgotten the fundamental question of Being, which has led to a profound disconnection from the world and us. Heidegger conveys that “Being” is not simply a thing that exists but is the foundation of our existence. It is the question of what it means to be, and it requires constant questioning and contemplation to understand our place in the world fully. In Heidegger’s words, we do not exist as isolated individuals but are just as we are “committed to Being-in-the-world”, so too are we committed to “Being-with-others” (p. 115). Moreover, Heidegger’s concept of ‘forgetting of Being’ is associated with the world of older people and connecting with others involves a deep engagement with the world, where they are not simply passive observers but active participants. This requires a certain openness and receptiveness to the world around them and a willingness to be affected by it.

Older migrants connecting with others is a significant notion in this thesis. Some participants had traumatic experiences and physical and psycho-social health problems, and their notable stories show their propensity to connect and engage in mind-boosting activities to avoid feeling lonely. Participants joined family and friends at social events and told of their involvement in social activities in the community centres. On reflection of its ethnic and cultural mix, Auckland offers culturally specific activities in community organisations, which caters to seniors to socialize and interact with others. Participants in this study also participate in places of worship and social outings as another form of social activity and to connect with others. Such pursuits and activities encourage older migrants to intermingle with other seniors, ultimately improving their physical and psychosocial well-being.

Furthermore, the literature supports the finding that loneliness and social isolation are linked to reduced cognitive function (Lara et al., 2020; Shankar et al., 2013). Hence, connecting with others is paramount in reversing this issue and promoting their health and well-being (Van Orden et al., 2020). Socialization among older migrants is a form of social inclusion and enables integration that supports a sense of well-being and belonging (Dobson et al., 2021). It should be noted that connecting with others does not necessarily solve memory problems per se, but it helps improve psychological well-being and keep the brain healthy.

“Learned optimism" is a concept developed by Martin Seligman (2011) that refers to the idea that people can learn to be more optimistic and create a more positive outlook on life, even in the face of adversity. According to Seligman, optimism is not simply a personality trait that some people are born with but a skill that can be learned and cultivated over time. He argues that we can develop a more positive and resilient mindset by changing our thought patterns and learning to challenge negative beliefs. Evidence suggests that Seligman’s learned optimism is essential in understanding how humans connect with others. Optimistic people tend to have a more positive outlook on life, leading to greater empathy, compassion, and understanding towards others. Based on that concept, this study shows how some participants have experienced hardship with MCI and learned to shift their thinking from pessimism to optimism. The previous section outlined stress, acculturation, social isolation, and participants' need to connect with others to alleviate memory problems. It is considered that adverse experiences during migration may have affected participants’ memory. Overall, while many factors contribute to a participant’s ability to connect with others, learned optimism can be substantial. By developing a more positive and resilient mindset, participants can cultivate greater empathy, understanding, and compassion towards others and build good memory to fulfil meaningful relationships.

Valuing culture

Cultural values can play an essential role in the experiences of older migrants. When older migrants from different cultural backgrounds move to an unfamiliar country, they often bring a unique set of cultures, values, beliefs, and traditions. These cultural values can shape their experiences of ageing which can influence how they adapt to and navigate the ageing process in an unfamiliar country with memory issues that are open to interpretation. Understanding the heterogeneity of their cultures and cultural views about MCI is critical to minimising misunderstandings.

Phenomenologically, Heidegger (1962/2008) posited the notion of ‘historicity’ that a person’s culture and heritage are influenced by being in the ‘occurrence’ (p. 18). Heidegger's concept is critical as his philosophy refers to how human beings are fundamentally shaped by their historical context and cultural background. According to Heidegger, cultural traditions, language, and historical experiences always facilitate our understanding of the world. By recognizing how our cultural background and historical experiences shape our understanding of the world, we can develop a more nuanced and reflective knowledge of ourselves and our place in the world.

This study raises the issue of ‘multiple jeopardies’ of being a migrant from an ethnically or socially diverse background and suffering from MCI (Harnois, 2015). The negative impact of them being a member of a marginalised social group simultaneously is more significant than that of another social group (Kern et al., 2020). Thus, being an older person, a migrant, or someone from a low-income background and being affected with MCI can have a multiplicative effect on that person rather than a mere cumulative effect. This dilemma includes prejudices, socio-cultural beliefs, faith-based opinions, and filial piety (Li et al., 2021; Sundlar et al., 2019).

Living with memory problems can be a challenging experience, and unfortunately, stigma is associated with this condition (Beller et al., 2017). Memory problems can be misunderstood or dismissed as a natural part of ageing or as a sign of intellectual weakness or memory decline. This can lead to feelings of shame, embarrassment, and isolation for individuals experiencing memory problems and can make it difficult for them to seek help or support (Dean et al., 2014). Participants mull over the stigma of living with memory problems. For many, MCI is interpreted as a condition similar to AD or a mental health problem, fearing MCI is a life sentence (Beard & Newry, 2013). Participants feel the label of MCI is a kind of stigma related to memory problems. This can also have wider social and cultural implications, as it can contribute to negative stereotypes and attitudes towards older people and individuals with cognitive frailties. This can lead to more discrimination and exclusion in various domains of life, including the workplace, healthcare settings, and social interactions. One common cultural misunderstanding is the potential progression of MCI to dementia, which adds more stigma to them (Garand et al., 2009; Lion et al., 2020).

One study showed older migrants experiencing adaptative challenges upon arrival to an unfamiliar country due to cultural problems that affected their traditional values (Hsu et al., 2004). Stigma and shame may prevent them from seeking psychological help. A unique perspective is presented in this thesis concerning the acquired knowledge and stigma relating specifically to MCI among older migrants in Aotearoa, New Zealand. Participants’ stories portrayed MCI as a harrowing experience in their culture and how this stigma affects their vulnerability (Lion et al., 2020). Cultural influences affect older migrants’ interpretation of MCI.

Moreover, in one example, the participant mentioned that problems with memory problems are related to a sinful past or having evil in the body (Owokuhaisa et al., 2020). Memory problems can be a symptom of various mental health conditions, but they can also be caused by physical health problems, medications, or simply ageing. While some perceptions of religious or spiritual beliefs may be associated with sin and negative consequences, such as guilt or spiritual harm, there is no evidence to suggest that sin directly causes memory problems. However, feelings of guilt or shame related to past actions may contribute to feelings of anxiety or depression, which can affect concentration and memory. Participants referred to possible past wrongdoing committed by themselves or a family member, something inherent to some Asian, Indian or Pacific cultures. The sinful past and its connection with mental health problems are found in many ancient other cultures connecting health, religion and morality (McKay & Whitehouse, 2015). Other studies induce a specific atmosphere of negative attitude towards understanding cognitive issues based on healthy or unhealthy religious interpretations (Lion et al., 2020; Woo & Mehta, 2017).

Filial piety was mentioned as a significant cultural issue by some Asian participants. Stories revealed the importance of caring for a sick or ageing family member. In the context of older people, filial piety often involves a range of caregiving, financial assistance and support such as home help and ensuring access to healthcare and other essential services. While filial piety can be seen as a positive value that promotes social harmony and support for older people, it can also create challenges and tensions in some situations. For example, in cultures where filial piety is highly valued, there may be expectations that adult children will provide care and support for their ageing parents, which can be difficult to fulfil in the face of economic, social, or other challenges. Additionally, some older people may feel pressure to rely solely on their children for support, which can limit their autonomy and access to other sources of support.

Cultural interpretation of filial piety conveys a variety of awareness and responsibility around someone with MCI (Li et al., 2021). For example, some participants cited Confucianism as a philosophy and a belief that they follow the family tradition. Older migrants who adhere to Confucianism may seek to meet their cultural needs in various ways. Confucianism is a traditional ethical and philosophical system that emphasises the importance of moral values, social harmony, and respect for authority and hierarchy. For older migrants who adhere to Confucianism seek out social and religious activities that reflect their cultural values. This may include participating in community events, attending religious services, or joining social groups available in the community. It may also involve maintaining relationships with family members and friends who share similar cultural or religious backgrounds with the philosophy of showing an ageing parent respect, love, care, and support (Woo & Mehta, 2017).

Participants consider themselves guardians of their culture and value their heritage (Bhugra, 2005; Tsai, 2005). Understanding such traditional cultural values is fundamental as it can affect clinical practice and help health professionals meet the differing needs of older migrants with MCI. Participants' stories show how they understand memory problems and describe cultural ways to reduce discomfort and fear. Attendance to family gatherings/outings, church activities, and other community social outings are revealed. Participants dealt with memory problems differently, and to circumvent this issue, and they revealed various management strategies described in the following sections.

Diagnosing MCI

MCI has been an equivocal factor in participants' lives regarding the relationship between their quality of life and living with cognitive issues. Some are compelled to seek clarity about their memory problems and give this meaning. A significant step was to understand the diagnosis with medical help. From a phenomenological perspective, Heidegger's (1962/2008) concept of "Knowing" indicates values attached to understanding these experiences. Heidegger's concept is a complex and philosophical idea that emphasises the importance of understanding and interpretation in human experience. According to Heidegger, humans do not simply "know" things objectively; instead, they always bring their values, perspectives, and interpretations of the world.

It is imperative to appreciate what makes sense in 'Being-in-the-world' from the perspective of someone with MCI. Some participants in this study express nervousness when they become aware of memory problems. Some report memory problems as dementia, some seek clarity and professional diagnosis, while others see it as a natural part of ageing. Some participants expressed concern about its long-term prognosis and treatments.

Pharmacological and non-pharmacological treatments are valuable mechanisms to provide comfort after being diagnosed with MCI. Some participants believe that innovations or other therapy would eventually ease memory problems. At the same time, some indicated that medication was not always the best solution: physical activity, reading, memory exercises and games, and singing seemed helpful ways to enhance the mind.

Collectively, the findings here resonate with the study undertaken by Beard and Neary (2013), suggesting that MCI is a medical condition, with many relying on doctors' explanations to obtain a clear definition. Seeking medical advice regarding memory problems remains a contentious issue. Some literature suggests that individuals with early memory problems often decline further medical diagnostic evaluation (Boustani et al., 2006; Fowler et al., 2015). This is possibly due to stigma, uncertainty about the future prognosis, and the inability to retain a driver's license if diagnosed (Fowler et al., 2015; Lion et al., 2020; Petersen, 2016). Some acknowledge MCI as a conditional part of ageing and suggest there is no reason to act upon it (Hussin et al., 2019). Yet, seeking medical help remains a significant step in understanding the fear of dementia.

Ageing and dementia

Participants described MCI as a normal ageing process, while a small group worried it was the prelude to dementia. It is not uncommon for individuals experiencing MCI to fear that it may be a precursor to dementia because it may significantly affect a person's ability to carry out daily activities. However, it is essential to understand that MCI is not the same as dementia and does not necessarily mean they will develop dementia.

Evidence points to forgetfulness resulting from an ageing process rather than brain disease (Geda, 2012; Joosten - Weyn et al., 2008). To alleviate fear, further research highlights memory tests as a valuable tool for diagnosing or clarifying cognitive problems in mild to severe cases such as dementia (Moreira et al., 2019). Even though some fear MCI may contribute to physical and psychological ill-health, many remain sceptical about a cure. On the other hand, Irwin et al.'s (2018) study contend that memory problems are distinct from typical ageing and pathological brain disease processes in dementia cases. Regardless of the different opinions, MCI is still considered an intermediary stage between healthy ageing and dementia, with ageing being a common risk factor (Geda, 2012; Lu et al., 2021).

There is no doubt that dementia can often be a terrible condition for both the individual and those close to them, affecting their health and wellbeing, dignity, and peaceful retirement. On that issue, being 'peculiar' has been emphasized as dasein, being in a world of forgetfulness or forgottenness (Heidegger, 1962/2008). Heidegger's philosophy offers some insights into how the fear of dementia affects individuals and their moods. Heidegger's concept of "Dasein" refers to how human beings exist and emphasises the significance of understanding human existence as a holistic phenomenon. One aspect of Dasein that may be relevant to the fear of dementia is the concept of "mood". Heidegger believes that moods are not simply emotional states that one experiences but are rather fundamental elements of our "Being-in-the-world". Fearful moods shape how an individual perceives and interacts with the world and can influence behaviour and attitudes. This fear could impact the individual's behaviour and attitudes, triggering them to withdraw from social interactions or activities they might otherwise enjoy. It could also affect their perception of their own cognitive abilities, instigating them to become hyper-vigilant or overly self-critical about their memory or other cognitive functions.

Narratives pointed to some participants downplaying the severity of MCI, despite describing incidents such as misplacing personal items, forgetting basic skills such as preparing meals, driving, and repeatedly asking the same question as possible signs of early dementia. For some, there was pessimism about the diagnosis, while others were realistic that MCI is an expected occurrence of ageing and a physiological phenomenon. Some saw themselves as a burden on family members, fearing loss of cognitive and physical abilities, while others worried about needing to move into aged-care facilities when their condition worsened. While it is understandable for individuals with MCI to be concerned about the risk of developing dementia, it is essential to remember that not everyone with MCI will develop dementia, and some steps can be taken to manage the condition and reduce the risk of progression. Understanding the complex interaction between thoughts, cultural values, and scientific factors can help professionals better support people with MCI who fear getting dementia and other age-related cognitive changes.

Stimulating the brain

The participants have expressed a positive attitude towards a particular activity or experience that they hope would stimulate their brains. This positive attitude is likely a result of their belief that the activity or experience has the potential to enhance their cognitive function and mental well-being. The reference to 'pleasant moments' suggests activities or experiences they find enjoyable or rewarding, such as spending time with loved ones or other seniors. Engaging in such activities gives them a sense of pleasure and satisfaction, which may help stimulate their brains and enhance their overall mental health. Indeed, some social and recreational activities help keep the brain active. Cognitive stimulation strategies make sense, but the meanings associated with such activities in the participant's daily life stories matter (van Manen, 2014).

There are abundant examples in the literature of strategies to help older people enhance memory through natural and medicinal approaches. Mental stimulation includes interaction with others, engaging in hobbies, games, reading, social engagement and good nutrition (NICE, 2018). Moreover, treating the underlying cause of MCI is often the best outcome for that individual. In the absence of specific medical treatment for MCI, non-pharmacological methods and culturally meaningful activities help improve cognitive health and well-being (Kim et al., 2015; Waites, 2012). Likewise, considerable evidence suggests that physical activity can also protect against cognitive decline in an ageing person (Callow & Alpass, 2014; Kim et al., 2015; Mandolesi et al., 2018). This view aligns with other studies suggesting physical exercise, such as walking for at least 150 minutes a week for a minimum of six months (Langhammer et al., 2018). Many seniors struggle to maintain such physical activity (Waites, 2012).

In contrast, some studies have not sufficiently demonstrated the effectiveness of lifestyle changes in treating MCI (Maass et al., 2016). Regarding the findings of this study, there is a consensus that physical and mental stimulation helps prevent the worsening of MCI symptoms. The participants' anecdotes remind us about the importance of exercise, reading and memory games to keep the brain supple. Attending cultural centres was an important activity that provided mentally challenging and physically diverse activities such as ballet exercises, singing, dancing and playing games. Different strategies cited as crucial to improving memory were daily walks, meditation, Tai Chi and playing Mah-Jong. In addition, non-pharmacological interventions such as herbal supplements to assist sleeping – St John's Wort and curcumin – were proposed as preventive strategies to improve memory loss symptoms.

Reflection

Reflection is a process of introspection and contemplation in which one can consider and examine their thoughts, feelings, and experiences. It is a way to gain deeper insights and understanding of oneself and the world around us (Wheeler, 2017). On the other hand, phenomenology is a branch of philosophy that studies the nature of a subjective experience, including perception, thought, and consciousness (Neubauer et al., 2019). Reflection involves reflecting on one's own experience, while phenomenology is a more formalized approach to exploring the nature of subjective experience in general and ensuring proper alignment between the specific research question and the researcher’s underlying philosophy (Neubauer et al., 2019; van Manen, 2014).

In presenting the findings, I reflect on the meanings of participants’ experiences and contrast the latest empirical and conceptual ideas on how MCI affects the lives of older migrants. The significance of MCI is relevant to clinical practice as it is to other stakeholders involved in the health of older migrants. Phenomenologically, I must understand people’s experiences with MCI as they appear. Most importantly, how they experience the world helps me understand the meanings attached to the phenomenon. This attribution is helpful because phenomenology is the study of beings at the heart of an account of human lived experience (Heidegger, 1962/2008). Reflecting on participants’ lived experiences enabled me to question how older migrants experience the world and gain a deep understanding of MCI. My goal is to create unique insights into MCI through the lived experience of older migrants, recognizing the complexities, prejudice, and human experience.

This study reflects my feelings as a researcher studying the willingness and readiness of 15 older migrants to share their lived experience of MCI. Every story is unique in how specific events impact them physically, psychologically, culturally and socially. Throughout this journey, I became aware of the individuality of the participants’ stories and how the knowledge gained provides a basis from which we can build essential knowledge of what it is like to live with MCI. I discovered the complexities of MCI and ascertained their coping strategies.

My role in this study is as an academic researcher. I acknowledge my professional experience in mental health settings and working with older migrants with memory issues. My mental health nursing background is a source of wisdom and experience for people with cognitive problems. I applied such knowledge to offer readers a phenomenological interpretation of the lived experience of older migrants with MCI. Lessons learnt show the complexity of human interaction that can affect or influence the researcher and the participant (Jack, 2008). Interviewing participants suffering from MCI can influence their interaction with the researcher. For example, participants may react otherwise because they know they are being watched or questioned. It can affect all kinds of behaviour, such as their daily habits and routine activities, because they may have great opportunities for instant change. The concept of the “Hawthorn effect” is referred to in this case as it can affect how the participants react when they are noticed, watched, and drawn to attention by an investigator (Parahoo, 2014).

Relatedly, the participants sought advice or support on the medical aspects of MCI to understand how to manage their memory problems. From the research point of view, I ensured that I was impartial and professional in my approach to answering questions. I offered necessary guidance and signposted participants where to receive specific aid, advice, and support on MCI without infringing on my professional background.

As a phenomenological researcher, developing a nuanced approach to spoken and nonverbal communication is fundamental. During interviews, I sought to elicit stories with a hermeneutic connotation, relying on the detailed description of some aspects of lived experiences (Davidsen, 2013). However, while language was sometimes a communication challenge, translators helped explain and capture the experiences. Overall, interviews have been conducted consistently to reveal meaningful stories and provide a professional interpretation of the experience.

During data interpretation, I learned the known and unknown messages behind the phenomenon of MCI. In retrospect, I understood there was some naiveté on my part, and I took my beliefs and understanding of this phenomenon for granted. I initially perceived MCI as being an early stage of dementia. However, the unknown factor was that older migrants experienced memory problems differently. Physiologically and physically, both conditions differ. On this issue, van Manen (2014) suggested that our common-sense assumptions and pre-assumptions prompt us to interpret the nature of a phenomenon before dealing with its importance. I understood that stories disclosed by someone with memory problems offered a mixture of known and hitherto unknown facts. When reconciling beliefs, prejudices, and assumptions, I realized that this study explores the meaning of living with MCI from the participants' perspectives, not mine. I assumed that those with MCI can speak about individual experiences because much of their long-term memory is still intact. MCI mainly affects short-term memory, which would not have been the case for those more impaired. By focusing on older migrants with MCI, I felt that learning from their experience would benefit other seniors with MCI and even those more impaired. Everyone brings specific knowledge and expertise to a conversation that helps guide education regarding prevention, planning and treatment. I consciously reflected on my research experience in this study and learned what lies in the daily lives of older migrants with memory problems. Lessons learnt do not offer solutions to the problem of MCI in the traditional sense; instead, it traces a path that opens up to focus on the educational issue to support further research (Kruger-Ross, 2015).

Implication for practice

This thesis has implications for the stakeholders' providing services for older migrants with memory problems. Findings showed concerns for older migrants living with MCI and their strategies to manage this condition. It highlighted issues around quality of life, physical and psychological well-being, and cultural significance. Participants were pleased and grateful for initiatives from central and local governments to improve their psychological well-being. While these initiatives specifically target seniors, older migrants reap the same benefits. The advantages of financial support come from superannuation, health checks, and free public transport, enabling access to community centres, which were all valuable schemes participants appreciated. It is commended and highly desirable to continue these incentives. Findings confirm its importance to healthcare professionals working in gerontology and older migrant populations. Aotearoa New Zealand’s health systems recognize positive ageing as a vital matter for seniors (Parr-Brownlie et al., 2020). However, the experience of older migrants who age with MCI is significantly different from other ethnicities. The significant increase in the older migrant population is expected to bring new opportunities and challenges for health professionals to meet the needs of this population.

In Aotearoa New Zealand, the MOH (2017) has already stressed the need to improve health and services for seniors in their later years. Other key research outcomes support the government’s commitment to age-friendly initiatives for all seniors (Neville et al., 2018; Parr-Brownlie et al., 2020). The findings of this study provide more insight into ways to improve policies and practices for stakeholders working with older migrants with MCI. Strategic policies and financial support are necessary to improve service delivery, guidance, and action plans. It is noteworthy that government policies support a preventive approach for the older population to promote their health and wellbeing (MOH, 2017, MOH, 2018; MSD, 2020). As MCI can be treatable in many cases, successful ‘healthy ageing’ models are purported as strategies to improve the cognitive health and wellbeing of older migrants in Aotearoa New Zealand (MOH, 2017). While the needs of older migrants with MCI have already been shown, cultural awareness and sensitivity must be further investigated. Local and central governments have essential roles and have already achieved much in ensuring that older migrants retain, interpret and express their own cultures, especially those with memory problems. Policy changes require a thorough understanding of the impact of MCI on older migrants to provide more culturally relevant community centres.

It is important to note that managing the health and well-being of older migrants with MCI in primary and secondary care is complex, cultural values and the complexities of older migrants acculturing in Aotearoa New Zealand, must be addressed. My recommendation is that older migrants must be recognised and given a voice in better planning of services to meet their needs and reduce barriers.

Notably, one practice implication is the assessment and treatment of MCI. Central and local council legislation needs to direct more resources to health authorities with incentives and strategic advice on the assessment, management and prevention of MCI. Participants attached immense importance to seeking diagnostic clarity of their memory problems and advice about treatment. GP practices are the first port of call for health advice and clarification about the long-term impact of MCI. This study recommends that primary care services offer this group more preventive care and support. Equally important is raising awareness and improving primary and secondary care services for older migrants in public health education, cultural and socially appropriate initiatives and long-term support.

Previously, significant gaps and shortcomings were noted in health disparities for older New Zealanders (MOH, 2001). The WHO (2020) recognizes that older people diagnosed with MCI can progress to AD much faster than those without the symptoms. At the beginning of this study, I mentioned the perception that MCI occurs in people with cognitive impairment on a continuum. Over time, MCI can become a form of dementia. However, early detection is paramount from a governmental preventative perspective; the sooner older people get help and support, the better. Presently, the *"Healthy Ageing Strategy*" and the *"Better Later Life: He Oranga Kaumatua 2019 to 2034*" strategies are in place to support older New Zealanders (MOH, 2016b). Both approaches focus mainly on the ageing population, physical health problems, and psychological issues. However, these strategies are broad and not specific to the needs of older migrants or the case of MCI. A recent study by Ma'u et al. (2021) found a substantial risk factor associated with dementia among the main ethnic groups in Aotearoa New Zealand. That study suggests that almost half of such cases are potentially preventable if the identified risk factors are eliminated. Since people with MCI have a higher risk of developing dementia, this study recommends considering more specific strategies to support an ever-growing ethnically diverse population of older migrants.

Other MOH (2013, 2014, 2018) publications, *"Improving the Lives of People with Dementia", The New Zealand Framework for Dementia Car*e", and the recent *"He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*" are strategies to provide people with cognitive problems such as MCI with an early diagnosis. However, this policy is broad and targets all older people but not older migrants with MCI. Guidance to health professionals working with older migrants concerning practical improvement is much needed in this field. Specific policies are required to improve access and meet the socio-cultural needs of older migrants. Progress in managing MCI is also necessary to strengthen best practice guidelines for a sustainable future. The government recognises that mental distress in older people may arise from cognitive decline, grief and loss, role changes and loss of function, loneliness, isolation and stigma. Hence, strategies are needed to recommend a new approach to achieve lasting improvements for older migrants with MCI.

Older migrants with MCI need a gracious and respectful quality of life and a significant improvement in health impartiality (MOH, 2017). Further practice-based research is recommended to better understand older migrants living with MCI to improve clinical practice and better support this group.

Implications for education

Education plays a critical role in disseminating information on MCI to health professionals and other stakeholders involved with older migrants. As stated earlier, MCI is a common condition that affects many older adults, significantly impact their quality of life, including their ability to live independently, manage their finances, and maintain social relationships. Health professionals play a crucial role in the education, identifying and managing MCI. They need to thoroughly understand the condition, including its symptoms, causes, and risk factors. Education on the latest research and best practices for managing the condition is needed, including pharmacological and non-pharmacological interventions. To this end, the WHO (2015) supports the prevention and treatment of neurocognitive disorders, such as MCI, as a global public health priority.

Education on MCI can take many forms, including workshops, training sessions, webinars, and conferences; learning from the participants' experiences could shape more effective educational practices. It is essential to ensure that education on MCI is accessible to all stakeholders, regardless of their background or level of education. Education in multiple languages may also be necessary to reach diverse migrant populations.

One study has examined the potential relationship between education and those with memory problems and considered the increased risk factors (NIA, 2019). Lifestyle choices do not fully explain the relationship between low education and those with cognitive problems compared to those with higher education (NIA, 2019). In contrast, it is thought that people with a higher level of formal education may have a more vital ability to help prevent the deterioration of their cognition than those who do not. However, some studies have shown that brain pathology has nothing to do with educational status; education has not protected people from neurodegenerative diseases such as MCI or dementia (Brayne et al., 2010). This literature seems insufficient to illustrate a relationship between the lack of education and its impact on people with memory problems. There seems to be apprehension about the difficulties faced by those with MCI. As Matyas et al. (2019) noted, education is a solid indicator for raising awareness of MCI. Still, continuing education highlighting the causes, prevention, care and treatment of MCI is recommended in Aotearoa New Zealand.

Moreover, MCI education is essential because older migrants are a high-risk group, so secondary and tertiary education providers must include this topic in their curriculum (Geda, 2012). Indeed, there are many educational incentives toward strategies for prevention and providing health education on cognitive problems worldwide. A systematic review pointed to MCI education, enriching knowledge, improving social skills, and health promotion (Matyas et al., 2019). Strategies to raise public and professional awareness about MCI are crucial to understanding the root causes and symptoms of MCI. It is recommended to improve education for early screening, develop self-assessment tools and provide educational support for brain imaging technologies (Giau et al., 2019; NIA, 2019; Weir, 2019). Education on prevention strategies is preferable as it would help those in the initial stages of MCI before their symptoms worsen. These would be ideal venues for government services and NGOs to disseminate information on aspects of MCI. Older migrants in this study attach immense importance to community cultural centres, where such education could be targeted.

Aotearoa New Zealand has seen a steady increase in older migrants, stressing the need for more learning on MCI for all stakeholders, specifically in health and social care curricula

(Stats NZ, 2018). Dissemination of MCI education to the public can be provided directly by care providers, NGOs and primary and secondary health providers. Specific courses related to MCI can indirectly support higher education for health professionals engaged in graduate programs or staff taking professional development courses. From a nursing education standpoint, emphasizing healthy ageing and MCI in undergraduate and postgraduate nursing courses cannot be overstated.

Pedagogy changes may involve incorporating MCI education into training healthcare professionals, caregivers, and NGOs for older migrants. Educational interventions can focus on developing effective communication strategies for managing the condition and teaching practical skills to support individuals with MCI. My recommendation from this study is to include MCI in all pedagogy and communicate the experiences learnt from older migrants to the broader tertiary providers. By increasing awareness and understanding of the condition, health educators can improve the quality of life of those affected by MCI and ensure they receive the care and support they need.

Implications for research

The findings on MCI highlight the need for policy, practice, pedagogy changes, and further research. MCI is a complex condition that can significantly impact the lives of older migrants and their families, so it’s essential to develop effective policies and practices to manage and prevent its occurrence. Research influences policy changes, including developing national guidelines for the identification and management of MCI, providing funding for research on MCI, and creating programs that target the prevention of cognitive decline in older people. Research can also include initiatives that promote awareness and education about MCI among healthcare providers, caregivers, and the general public. Clinical practice changes may involve the development of screening tools for MCI, the creation of specialised clinics for the diagnosis and management of MCI, and the provision of targeted interventions to improve cognitive function in those affected by the condition.

Research on MCI and, in particular, as it occurs in older migrants is still lacking, as most empirical studies focus primarily on cognitive impairment (Hansen et al., 2018; Kanengoni et al., 2018; Liu et al., 2020). Currently, a large amount of MCI-related research is on aetiology, epidemiology, and risk factors in the older population (Kasper et al., 2020; Petersen, 2016; Petersen et al., 2001) but does not address specifically older migrants (Canevelli et al., 2020; Xu et al., 2017). Although MCI remains an active area of research, more is needed to increase awareness, encourage better understanding, explore providing adverse risk factors associated with MCI, and focus on pharmacological and non-pharmacological treatments (Kasper et al., 2020; Petersen, 2016; Shimada et al., 2019). Research on older migrants and specificity around MCI is scarce (Bampa et al., 2017). This thesis focuses on MCI from a unique perspective of older migrants through a phenomenological lens. Additionally, initial findings were presented locally (Jauny et al., 2018a, b) (See Appendix L for total research output), and the plan is to disseminate more after publication. The current findings indicate that more research is needed to focus on older migrants with MCI and consider the broader population's socio-cultural implications.

Phenomenology provides an excellent framework for understanding the social sciences by interpreting individual evidence (van Manen, 2014). The findings in this study highlight the personal and socio-cultural ethics associated with MCI among older migrants. Findings have added nuances of information on cultural perspectives, acculturation difficulties, language barriers, feelings of isolation, and the importance of connecting with others. It points to the need for further research on similar issues affecting older migrants, exploring the phenomenon of living with MCI. This thesis has focused on a handful of migrants from seven countries, primarily of Asian origin.

In contrast, empirical research on MCI elsewhere has distinguished seniors from the general population to the specificity of older migrants (Lu et al., 2009; Xu et al., 2020). Given this study's limited number of participants, a wider migrant population would be an important area for future research. This research sets a benchmark for understanding cognitive difficulties from the perspective of older migrants in Aotearoa New Zealand. Learning from their experiences is vital to appreciating the socio-cultural factors that might affect other populations.

In this study, participants expressed concern about registering the causal factors of memory problems and sought medical recognition to confirm, manage, or treat symptoms. Coping mechanisms differed, but an understanding of MCI and strategies for self-help were similar. Future research could focus on strengthening diagnostic tools, exploring cultural and ethnic awareness prospects, and looking at alternative ways to treat those with MCI. Further research on MCI might offer more preventative risk factors, such as modifying lifestyle choices. It might investigate the acculturation stress of migrating to a new country and explore coping strategies and support structures for older migrants. Future research could also consider differences between older migrants and the general older population. Further research is also needed to understand better the causes, risk factors, and long-term outcomes of MCI. This research can inform the development of more effective prevention and management strategies for the condition.

Recommendation emphasises the need for policy, practice, pedagogy changes, and further longitudinal research. This is essential to improve the identification, prevention, and management of MCI and the quality of life of older migrants affected by this condition.

Strengths and limitations

Aotearoa New Zealand has a large migrant population which is reflected in the diversity of cultures. In this study, older migrants were chosen on a 'first-come, first-served basis'. Hence, the selection of participants was not proportionate to the entire migrant population. The findings of this study cannot be generalized, but stories from the experiences of older migrants offer a revealing insight into what it is to live with MCI. However, several limitations also need to be acknowledged.

The strength is examining through a phenomenological lens which enhances the human factor, wealth of knowledge, and depth of qualitative data (Neubauer et al., 2019). Once again, phenomenology is not about the amount of data but the richness of unique and meaningful qualitative stories (Crowther et al., 2016; Laverty, 2003). The robustness of the findings demonstrates the first-hand experience of older migrants with MCI. Due to the high degree of impairment, it is difficult to get similar findings from people with severe cognitive decline. However, lessons learnt may be valuable and transferable to other older adults with MCI and those with more severe cognitive health problems.

The first limitation is that it was undertaken in one geographic area, Auckland, New Zealand, and therefore cannot reference older migrant populations in other parts of the country or the world. Moreover, transferability to other cultural groups must be considered, given the universality and uniqueness of migrant populations. Nevertheless, this may also be appropriate for health professionals in different fields in central and local government agencies. To generalize from findings is not a feature of a phenomenological study; however, the similarity of participants' experiences can be comparable to other older migrant populations.

The second limitation is the inclusion of participants who could have basic conversations in English. This criterion may have excluded many other older migrants who could otherwise have shared stories about their experience of MCI. Although an interpreter was available, getting one for all spoken languages was challenging.

The third limitation is the potential bias of being both a mental health nurse and studying the subject of MCI as an emerging phenomenological researcher. Participants' stories were described, and the data were interpreted with phenomenological thinking. My professional understanding may have influenced the interpretation of MCI experiences. By sharing my professional knowledge of the phenomenon, I recognize that the findings could be interpreted differently. In contrast, the strength of this study is arguably my mental health background of working with older people of different severities of cognitive problems. My knowledge, skills and experience working with older migrants have helped me better recognize what it is like to have MCI in this group.

Phenomenology is a unique methodology in which care professionals can learn from an individual's lived experiences (Neubauer et al., 2019). However, suffice it to say that this study was limited purely to older migrants, but the voices of their partners, family members or other meaningful people known to them could not be included in the data collection. I did not collect extensive numerical data and other quantitative features due to an ontological view of the study. This research approach employs phenomenology to understand individuals' subjective experiences and meanings. The goal is to describe and interpret the essence of the lived experiences of individuals without making assumptions or judgments about objective reality. In other words, phenomenology recognises that individuals have unique experiences and interpretations of the world around them and that a range of factors, including culture, personal history, and individual differences, shapes these experiences and interpretations. Therefore, when conducting phenomenological research, it is essential to acknowledge that the findings are not necessarily representative of objective reality but rather the participants' subjective experiences. Researchers should also be transparent about their biases and assumptions and strive to avoid imposing their interpretations on the data. Hence, the interpreted meanings of the stories collected through this research are typically presented for readers to study and ponder. This allows readers to engage with the data and draw conclusions rather than being presented with a pre-determined interpretation (Crowther, 2014).

Original contribution

The primary purpose of academic research is to contribute to existing knowledge and bring new insight and present original contribution to the topic being investigated. In the case of this study, exploring the lived experience of older migrants with MCI, the primary purpose was to gain a deeper understanding of their experiences. This research aimed to contribute to the existing knowledge of MCI and showcase how to improve the care and support for older migrants with the condition. Earlier, I revealed a gap in knowledge in the literature on this issue. The findings of the study contribute to future cross-disciplinary research on the welfare of older migrants in Aotearoa New Zealand, and other countries with high migrant populations.

By exploring the experiences of older migrants with MCI, this study highlights the importance of culturally responsive and linguistically appropriate care and support for this population. The findings can inform the development of future research that seeks to investigate the effectiveness of culturally responsive care approaches and interventions for older migrants with MCI. Findings could also contribute to developing policies and practices that support the health and well-being of older migrants in general. Policymakers and practitioners would be able to understand better the needs and challenges faced by older migrants and inform the development of strategies that promote their health and age gracefully.

This thesis has contributed a distinctive hermeneutic approach to exploring the lived experience of older migrants with MCI. Indeed, interpretive phenomenology presents a unique methodology for inquiring into an individual’s lived experience (Frechette et al., 2020). This study contributed to a wealth of existing information on MCI and provided a good understanding of how it affects the lives of older migrants in Aotearoa New Zealand. Moreover, it represents the voices of older migrants in academic research, which can potentially improve their well-being and quality of life. Lessons learned can initiate changes in how stakeholders perceive older migrants by minimizing attitudes taken for granted and cultivating a good understanding of MCI. Another significant contribution of the study is its focus on the heterogeneity of older migrants with MCI and the similarities to dementia. This study recognises that experiencing MCI varies among individuals, but some of the symptoms and challenges associated with MCI are similar to those experienced by individuals with dementia. The findings suggest that cultural factors, such as language barriers, cultural beliefs, attitudes towards ageing and cognitive decline, can significantly impact how older migrants experience and interpret MCI.

Closing remarks

At the start of this thesis, I emphasised the prevalence of MCI among older migrants in Aotearoa New Zealand. I uncovered that as migrants age, their memory worsens too (Petersen, 2016). It was heartening to expose a research gap in the phenomenon of MCI amongst older migrants in Aotearoa New Zealand. Hermeneutic phenomenology has provided a transparent way to understand the lived experience of older migrants. Indeed, phenomenology enables the reader to be better informed about MCI from the point of view of older migrants. It also aided the interpretation and attribution of the meaning of the condition (Frechette et al., 2020). I recognise the insights one track that lay "hidden" in showing an experience and interpreting the meaning of others (Smyth & Spence, 2020).

Engaging in phenomenological research requires a philosophical understanding of human experience (Neubauer et al., 2019). Participants' stories revealed what MCI meant and how they made sense of this condition. They are now "phenomenologically hermeneutic" in their ways, seeking the meanings that arise when one dwells considerately on how things are (Smythe & Spence, 2020). The wealth of information from the collected descriptions of events forms part of four chapters depicting the lived experience of older migrants with MCI. The findings contrast the ABC model of Seligman (2011) by showing how to understand and interpret the findings of this phenomenon. The ABC concepts highlighted an Antecedent in the context of time, place, persons, and events within an experience (Gadamer, 1994); the Behavioural experience and its responses to the constraint of public and private behaviours (Heidegger, 1962/2008); and its Consequences of the fundamental ontological views of how one can make sense and find the meaning of the lifeworld (Crowther & Thomson, 2020).

The experience of forgetting day-to-day concerns older migrants about their vulnerability when they have memory problems. Such initiatives involve using theory to attribute feelings, beliefs, or intentions to understand an individual's behaviour (Crowther & Thomson, 2020). Heidegger (1962/2008) also reminds us that forgetfulness or forgotteness contributes to the expressions and self-awareness of people with memory problems. Participants shared stories of embarrassment, angst and frustration that impacted their aspirations of living pleasurable lives.

One notion has shown how older migrants are influenced by inevitable misfortunes or life events contributing to harrowing experiences. Subsequently, such incidents were outlined regarding how such adversities affected their cognitive function. There is a resonance with past traumatic events; experiencing aloneness, relationship problems, retirement challenges, acculturation stress, inability to continue driving and enduring physical health complications. Being thrown is shown as a significant notion, which causes angst, as depicted in Heidegger's (1962/2008) "Being and Time". Participants' anecdotes show how being thrown into such events daily hampers their psychological comfort and affect their memory.

Another significant phenomenon is the coping mechanism of older migrants connecting with family, friends, and members of community organisations in their local area. Heidegger (1962/2008) refers to feeling lonely in the concept of "existential isolation" as an integral component of human existence. Heidegger also points to connecting with others when he refers to an individual as "Being-in-the-world". Community organisations for seniors are essential because they provide regular activities with cultural relevance to stimulate the mind, improve psychological wellbeing, and link to background and heritage. Heidegger's (1962/2008) view of "Being-with-others" is essential to understand what participants make sense of "Being in the world". Connecting with others and understanding cultural and spiritual beliefs is critical for managing memory problems in the older migrant population.

The findings uncover different strategies to make sense of living and coping with memory problems. The underlying ontological understanding of older migrants shows how they interpret the meaning of their experience (Crowther & Thomson, 2020). Participants' stories show how memory problems are sometimes seen as an ageing problem that requires more education and understanding for older migrants and those close to them. Older migrants' narrative advocates that they need more support when they forget routine basic tasks, experience embarrassment when they are repetitive, and face negative connotations or stigma about MCI. In contrast, sharing pleasant moments, weighing the importance of family support, and strategising positive attitudes toward accepting MCI seems to improve their mental wellbeing.

An examination of the world of an older migrant with MCI highlights the multiple jeopardies of living with this condition. Government policies have partly addressed the needs of older people with MCI, but more could be done to find specific support for older migrants. Based on the findings in this thesis, it is hoped that Te Whatu ora's, NGOs and local councils will provide more support initiatives for older migrants with MCI. Future research should be considered, specifically a longitudinal study on the lived experience of older migrants and other populations with MCI. This thesis has brought forth the voices of older migrants with MCI and embodied their gratitude, enthusiasm, and sense of accomplishment. Negative connotations about this particular group must be acknowledged and shared with stakeholders who provide the appropriate care and services to older migrants. This thesis presented an empirical and influential example of MCI as a severe problem for older migrants in Aotearoa New Zealand.

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Appendices

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Appendix A Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)
Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

29 October 2018

Stephen Neville
Faculty of Health and Environmental Sciences

Dear Stephen

Re Ethics Application: **18/114 The lived experience of older migrants with mild cognitive impairment in New Zealand**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 29 October 2021.

Non-Standard Conditions of Approval

1. Ensure that the wider range of support services are referred to are in the Information Sheet.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/research/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/research/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation, then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee Cc: rjauny@unitec.ac.nz

Appendix B: CMH Locality approval

COUNTIES
MANUKAU
HEALTH

Research & Evaluation Office
Level 1, Ko Awatea, Middlemore Hospital
100 Hospital Road, Otahuhu; Private Bag 93311, Auckland – 1640
cmdhb.org.nz – koawatea.co.nz

12 February 2019

For the attention of: Ray Jauny

Thank you for the information you supplied to the CMH Research Office regarding this research proposal:

Research Registration Number: 753

Ethics Reference Number: 18/114

Research Project Title: The lived experience of older migrants with mild cognitive impairment in New Zealand

I am pleased to inform you that the CM Health Research Office has received all the required Locality approvals and final sign-off by the Chief Medical Officer for this research project, which has you named as the Principal Investigator and Hanna Jauny as the CMH Facilitator.

Your study is approved until 29 October 2021, the date specified on your ethics application.

Please note that failure to submit amendments and external reports may result in the withdrawal of Ethical and CM Health Organisational approval.

We wish you well with your project. Please inform the Research Office when you have completed your study (including when a study is terminated early) and provide us with a brief final report *(template available on request)* which we will disseminate locally.

Yours sincerely

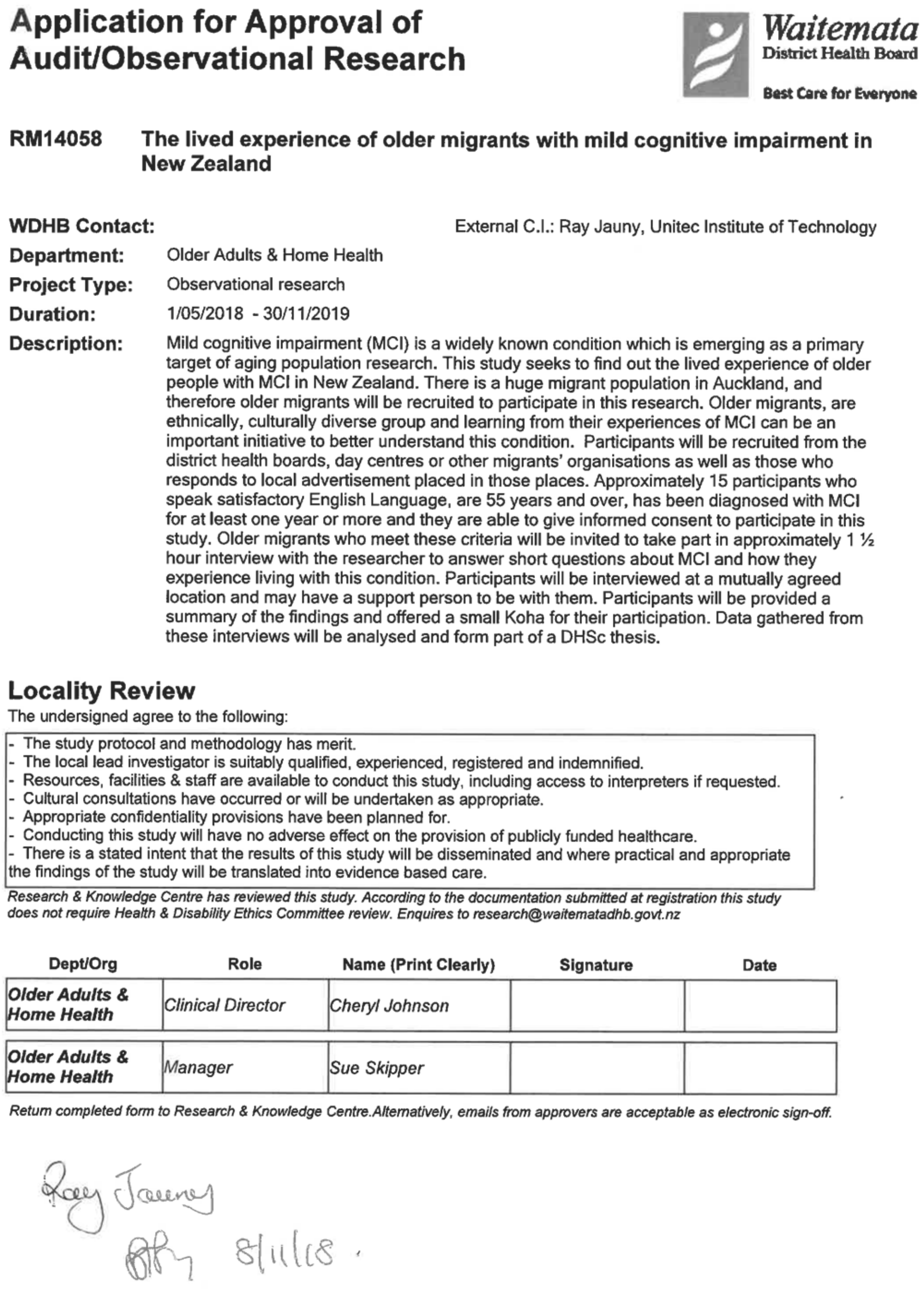
A Bennett.

Angela Bennett

Research Coordinator
Counties Manukau Health

Under delegated authority from CM Health Research Committee and the Chief Medical Officer

Appendix C: WDHB Locality approval



Application for Approval of Audit/Observational Research

Waitemata
District Health Board
Best Care for Everyone

RM14058 **The lived experience of older migrants with mild cognitive impairment in New Zealand**

WDHB Contact: External C.I.: Ray Jauny, Unitec Institute of Technology

Department: Older Adults & Home Health

Project Type: Observational research

Duration: 1/05/2018 - 30/11/2019

Description: Mild cognitive impairment (MCI) is a widely known condition which is emerging as a primary target of aging population research. This study seeks to find out the lived experience of older people with MCI in New Zealand. There is a huge migrant population in Auckland, and therefore older migrants will be recruited to participate in this research. Older migrants, are ethnically, culturally diverse group and learning from their experiences of MCI can be an important initiative to better understand this condition. Participants will be recruited from the district health boards, day centres or other migrants' organisations as well as those who responds to local advertisement placed in those places. Approximately 15 participants who speak satisfactory English Language, are 55 years and over, has been diagnosed with MCI for at least one year or more and they are able to give informed consent to participate in this study. Older migrants who meet these criteria will be invited to take part in approximately 1 ½ hour interview with the researcher to answer short questions about MCI and how they experience living with this condition. Participants will be interviewed at a mutually agreed location and may have a support person to be with them. Participants will be provided a summary of the findings and offered a small Koha for their participation. Data gathered from these interviews will be analysed and form part of a DHSc thesis.

Locality Review

The undersigned agree to the following:

- The study protocol and methodology has merit.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities & staff are available to conduct this study, including access to interpreters if requested.
- Cultural consultations have occurred or will be undertaken as appropriate.
- Appropriate confidentiality provisions have been planned for.
- Conducting this study will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that the results of this study will be disseminated and where practical and appropriate the findings of the study will be translated into evidence based care.

Research & Knowledge Centre has reviewed this study. According to the documentation submitted at registration this study does not require Health & Disability Ethics Committee review. Enquires to research@waitematadhb.govt.nz

Dept/Org	Role	Name (Print Clearly)	Signature	Date
Older Adults & Home Health	*Clinical Director*	*Cheryl Johnson*		
Older Adults & Home Health	*Manager*	*Sue Skipper*		

Return completed form to Research & Knowledge Centre.Alternatively, emails from approvers are acceptable as electronic sign-off.

Ray Jauny

8/11/18

Appendix D: Participant information sheet

Participant Information Sheet

Date Information Sheet Produced:

23/05/2018

Project Title
The lived experience of older migrants with mild cognitive impairment in New Zealand

An Invitation

Kia ora,
My name is Ray Jauny, and I am currently doing research as part of Doctor of Health Science (DHSc) degree at Auckland University of Technology.
I would like to invite you to participate in my research project. Your participation is voluntary, and it is entirely your choice. If you agree to participate, you will be asked to sign a consent form. This does not stop you from changing your mind if you wish to withdraw your consent. Your contribution will not advantage or disadvantage you in your current care and treatment through your participation or no participation in this project. If you choose to withdraw, you will be offered the choice between having any identifiable data as belonging to you removed or allowing it to continue anonymously. However, once the findings have been produced, the removal of your details may be difficult.
Over the past 20 years, I have been privileged to have worked as a mental health nurse with older persons from a diverse background. I have met many people with mild cognitive impairment, and my objective is to understand better older migrants living with this condition.

What is the purpose of this research?
The purpose of this study is to understand better the lived experiences of older migrants who have mild cognitive impairment. This project is about you telling me how living with this condition has affected you and how you live your day to day life. The research project will be reported as a thesis to meet the Doctor of Health Science's award requirements. I also expect to gain publication in professional journals and will present the study to suitable conferences or symposiums in New Zealand and internationally.

How was I identified, and why am I being invited to participate in this research?
I am contacting you because you have spoken to me and informed me that you have mild cognitive impairment. You have either responded from an advertisement or received information from a professional working in the DHB regarding this study.
You are invited to participate because you are an older migrant, aged 55 years old or over and living in New Zealand between one to ten years.

How do I agree to participate in this research?

If you agree to participate in this research, I will contact you personally to have a brief conversation with you about your cognitive problems. I will then ask you a few questions to check whether you can provide consent to participate in the study. If I'm not sure about this, I will check with your doctor. If there is a cost for this, I will pay for it.

What will happen in this research?

If you decide to participate in this research project, I will require approximately 1 to 1 ½ hour of your time and meet you at a mutually agreed venue for an interview. If you wish, you may bring along a support person for the interview duration. The interview will be audio recorded. You will be asked to answer a few questions in the English language about your own living experiences with this condition. You can inform me about both positive aspects of it and the challenges you have had over time. For example, I will ask you questions such as: "tell me about the particular moment in time when you were told you have cognitive problems"; "tell me how you live your daily life because of this condition" and "tell me what it is like to have a mild cognitive impairment."

In the end, your stories will be analysed and typed written. A summary of what you state in the interview will be given back to check if it has been reported correctly. If everything you have said is correct, then the information will form part of my thesis.

What are the discomforts and risks?

You may find it uncomfortable to recall stories about your past from when you first became aware that you have memory problems. This can be unpleasant or even embarrassing. But don't worry, as this is a normal response as we see ourselves from a different angle in today's world. It is normal to realise that your memory is not the same as previously. However, this research aims to learn from those experiences, and your stories can help us better understand this condition.

How will these discomforts and risks be alleviated?

If you feel uncomfortable while participating in this research, I will stop the interview. You may also terminate the interview earlier if you do not wish to continue without any consequence to you.

If you feel the discomfort is worse than you can manage, I will offer you support and guidance. I will request that you see a counsellor at the AUT Health Counselling and Wellbeing. They can offer you free sessions of confidential counselling support. These sessions are only available for arisen issues because you participated in this research and are not for other general counselling needs. To make an appointment for these services, you will need to:

Chapter 1 Phone the City Campus on 0921 9992, or
Chapter 2 Phone the North Shore Campus, on 0921 9998, or
Chapter 3 Phone the South Campus, phone number 0921 9992
let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling at this website, *http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and wellbeing/counselling*.

You may also seek support at Alzheimer's society Auckland, Age Concern or other cultural societies with a specific association with your cultural background.

What are the benefits?

Chapter 1 The research will benefit you and other older migrants by learning from the experiences you will share.

Chapter 2 It has the potential to provide valuable insights to other New Zealanders living with mild cognitive impairment.

Chapter 3 The findings can be used by health professionals and the ministry of health to improve the care for older migrants and other older people with this condition.

Chapter 4 It can help older migrants and their families to better adapt to New Zealand health care services.

Chapter 5 A Koha of $40 of supermarket voucher will be given to you for your contribution.

How will my privacy be protected?

Your participation will be kept confidential because the intention is to protect you from any unpleasant effects that may result from your participation or no participation in this research. Any quotes used in the writing up of the research findings will use a different name of yours to maintain your name confidential unless you wish to seek acknowledgement of your contribution.

What are the costs of participating in this research?

There is no financial cost involved for you to participate in this project. However, approximately 1 to 1 ½ hour of your time will be required.

What opportunity do I have to consider this invitation?

You will be given four weeks to decide if you wish to participate in this research. Before the four weeks, I will send a reminder to you if you have not responded within this timeframe. After that, I will not contact you.

Will I receive feedback on the results of this research?

Yes, a summary of the finding will be available to you if it is requested.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to

Project Supervisor:
Professor Stephen Neville
Head of Nursing
School of Clinical Sciences
Auckland University of Technology
90 Akoranga Drive,
Northcote, 0627
Phone: 09 921 9379
Email: sneville@aut.ac.nz

Concerns regarding the research's conduct should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team below for further details:

Researcher Contact Details:
Ray Jauny
Email **rjauny@hotmail.com**
Tel +64 9 815 4321 Ext 7456
Mob +64 0204228642

Approved by the Auckland University of Technology Ethics Committee on *29/10/2018,* AUTEC Reference number *18/114*

Appendix E. Consent form for participants

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Project title: ***The lived experience of older migrants with mild cognitive impairment in New Zealand***

Project Supervisors: ***Professor Stephen Neville, Dr Jed Montayre, Professor Valerie Wright-St Clair***

Researcher: ***Ray Jauny***

○ I have read and understood the information provided about this research project in the Information Sheet dated 29/10/2018

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that if I withdraw from the study, I will be offered the choice between having any identifiable data as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, my data's removal may not be possible.

○ I agree to take part in this research.

○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participants signature: ....

Participants Name: ....

Participant's Contact Details (if appropriate):

……………………………………………………………………………………..

……………………………………………………………………………………..

……………………………………………………………………………………..

……………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on 29/10/2018, AUTEC Reference number 18/114

Note: The Participant should retain a copy of this form.

Appendix F. Confidentiality Agreement for a transcriber

Confidentiality Agreement for a transcriber

Project title: The lived experience of older migrants with mild cognitive impairment in New Zealand
Project Supervisor: Professor Stephen Neville, Dr Jed Montayre, Professor Valerie Wright-St Clair
Researcher: Ray Jauny

○ I understand that all the material I will be asked to transcribe is confidential.

○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.

○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature : ....

Transcriber's Name : ....

Transcriber's Contact Details ....

....

Date:

Project Supervisor's Contact Details:
Stephen Neville
Professor & Head of Nursing
School of Clinical Sciences
Auckland University of Technology
90 Akoranga Drive,
Northcote, 0627

Approved by the Auckland University of Technology Ethics Committee on 29/10/2018 AUTEC Reference number18/114
Note: The Transcriber should retain a copy of this form.

Appendix G. Confidentiality Agreement for cultural advisor

Confidentiality Agreement for cultural advisor /support

Project title: The lived experience of older migrants with mild cognitive impairment in New Zealand

Project Supervisor: Professor Stephen Neville, Dr Jed Montayre, Professor Valerie Wright-St Clair

Researcher: Ray Jauny

○ I understand that all the material I will be asked to record is confidential.

○ I understand that the contents of the Consent Forms, tapes, or interview notes can only be discussed with the researchers.

○ I will not keep any copies of the information nor allow third parties access to them.

Intermediary's signature : ....

Intermediary's Name : ....

Intermediary's Contact Details (if appropriate):

……………………………………………………………………………………….

……………………………………………………………………………………….

Date:

Project Supervisor's Contact Details:

Stephen Neville
Professor & Head of Nursing
School of Clinical Sciences
Auckland University of Technology
90 Akoranga Drive,
Northcote, 0627
Phone: 09 921 9379 Email: sneville@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 29/10/2018 AUTEC Reference number 18/114

Note: The Intermediary should retain a copy of this form.

Appendix H. Confidentiality Agreement for an interpreter

Confidentiality Agreement for interpreter

Project title: The lived experience of older migrants with mild cognitive impairment in New Zealand

Project Supervisor: Professor Stephen Neville, Dr Jed Montayre, Professor Valerie Wright-St Clair

Researcher: Ray Jauny

○ I understand that all the material I will be asked to interpret is rial.

○ I understand that the contents of the Consent Forms, tapes, or interview notes can only be discussed with the researcher.

○ I will not keep any copies of the information nor allow third parties access to them.

Interpreter's Name : ....

Interpreter's signature : ....

Contact Details (if appropriate):

………………………………………………………………………………………

………………………………………………………………………………………

Date:

Project Supervisor's Contact Details:

Stephen Neville

Professor & Head of Nursing

School of Clinical Sciences

Auckland University of Technology

90 Akoranga Drive,

Northcote, 0627

Phone: 09 921 9379 Email: sneville@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 29/10/2018 AUTEC Reference number 18/114

Note: The Interpreter should retain a copy

Appendix I: Poster

AUT

TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

ARE YOU AN OLDER MIGRANT WITH MILD COGNITIVE IMPAIRMENT?

Would you like to participate in research so that your stories may help others?

I would like to hear from you if you have the following:

- You are 55 years old and over
- You have had mild cognitive impairment for at least one year
- You are a migrant from another country and living in New Zealand between one to 10 years
- You can spend approximately 1 to 1 ½ hours for an interview
- You can communicate in the English Language.

If you are interested in participating, please let me know:

Ray Jauny

Health Care Department, Waitakere 510/4007,
Unitec Institute of Technology,
Private Bag 92025, Victoria Street West, Auckland 1142
Email: **rjauny@hotmail.com**
Mobile: **0204228642**

A Koha of $40 worth of supermarket vouchers will be given to you for your contribution.

Approved by the Auckland University of Technology Ethics Committee on 29/10/2018, AUTEC Reference number **18/114**

Appendix J: Koha receipts to participants

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Receipt of Koha for research

Project title: *The lived experience of older migrants with mild cognitive impairment in New Zealand*

Project Supervisors: Professor Stephen Neville, Dr Jed Montayre, Professor Valerie Wright-St Clair

Researcher: Ray Jauny

This is to confirm that I have received a Koha for participating in this research

Name and signature

…………………………

…………………………

Appendix K: Interview Questions

Thank you for agreeing to take part in my research.

So please tell me about you *(your age, where you are from and your time in NZ)*

Tell me what you do on a day-to-day thing

Tell me what you did this morning before coming here *(tell me what happened?)*

Tell me about the last time you found your memory was not as good as before. *(What happened on that day?)*

Tell me about the time you first noticed doing daily things differently.

Tell me about a time recently when you felt your memory got in the way of doing something.

Please tell me what it is like for you to live with memory problems. Tell me a bit more about this.

Tell me, what is it like to live with this problem? (*How did that affect you?*)

Tell me about an enjoyable day you had recently.
What about a time recently when everything went well?

Tell me, what makes remembering or organising things to do easier?

W*hat else have you tried to help you remember?*

How does your memory influence your day-to-day activities, getting active?

How does your memory affect your life experience and your purpose in life?

What other experiences have you had with your memory?

Tell me about the last day you were with or looked after by your family

Tell me a bit about your life when you first arrived in NZ

What is it like to live as a migrant in this country?

What advice would you give to someone else living with MCI?

We talked about your memory today. Are there other things about your memory you would like to share?

Appendix L: Research outputs

Paper presented at symposiums and conferences between 2017- 2022

Jauny, R., Neville, S., Montayre, J., & Wright-St Clair, V. (2019, November). *The lived experiences of older migrants with mild cognitive impairment in New Zealand*: preliminary findings. Paper presented at the 9th Biennial International Indigenous Research Conference, Dunedin. http://www.indigenousresearchconference.ac.nz/

Jauny, R., Neville, S., Montayre, J., & Wright-St Clair, V. (2019, October). *The lived experiences of older migrants with mild cognitive impairment in New Zealand*: Preliminary findings presented at Knowledge Exchange Symposium, HOPE Foundation Auckland. http://www.hopefoundation.org.nz/newsletter/hope-foundation-november-2019/

Jauny, R., Neville, S., Montayre, J., & Wright-St Clair, V. (2019, November). *The lived experiences of older migrants with mild cognitive impairment in New Zealand*: Preliminary findings. Paper presented at Waikato University postgraduate conference. https://events.waikato.ac.nz/events/alpssgrad-2019-graduate-and-postgraduate-conference

Jauny, R., Neville, S., Montayre, J., & Wright-St Clair, V. (2018, November). *What is the lived experience of older migrants with mild cognitive impairment? A proposed phenomenological study*. Paper presented at the NZNO College of Gerontology Nursing conference in Hamilton. https://www.nzno.org.nz/Portals/0/Files/Documents/Groups/Gerontology/Conference%20and%20BGM/2018%20Presentations/Ray%20Jauny%20-%20Older%20migrants.pdf

Jauny, R., Neville, S., Montayre, J., & Wright-St Clair, V. (2018, September). *What is the lived experience of older migrants with mild cognitive impairment?* Paper presented at the New Zealand Association of Gerontology, "The Mosaic of Ageing" Ellerslie, Auckland. Retrieved from https://hdl.handle.net/10652/4451

Non-peer-reviewed oral and poster conference presentation:

Jauny, R., Neville, S., Montayre, J., & Wright-St Clair, V. (2018, October). *The lived experience of older migrants with mild cognitive impairment*, Paper presentation at Unitec Institute of Technology Symposium, Auckland.

Jauny, R., Neville, S., Montayre, J., & Wright-St Clair, V. (2018, June 21st). *The lived experience of older migrants with mild cognitive impairment*, Poster presentation at Ko Awatea, Counties Manukau Health, Auckland.