Meaningful living through engaging in physical activities;

Experiences of aged adults from two weeks to 18 months after a hip fracture

PhD dissertation

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List of original papers

Paper 1

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Paper 2:

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Paper 3

Rasmussen, B, Nielsen, C.V. & Uhrenfeldt, L. Being active 1½ years after hip fracture; aged adults' experiences of meaningfulness, a qualitative interview study: *In draft.*

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Abbreviations

HF	Hip Fracture
HCP	Health Care Professionals

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Contents

1 Introduction

This thesis, applying a longitudinal, phenomenological-hermeneutic perspective, investigated aged adults' experiences of the meaningfulness of being active within the 18 months after hip fracture (HF). People older than 65 years were initially referred to using the term "older adults"; however, to avoid labelling the people in the study as being frail before this was proven, the term older adults was replaced by the MeSH heading "aged adults" referring to people 65 years or older.

The planning of the PhD project was based on cooperation between Horsens Regional Hospital and four cooperating communities. Hospital and community leaders of rehabilitation departments were concerned about aged adults' increased dependency and loss of functioning after HF and wanted to develop rehabilitation practice based on evidence. With a years-long background of physiotherapeutic experience working with in-hospital rehabilitation of aged adults and cooperating with communities around discharge, I was assigned to do a PhD study.

The cooperation of hospitals and communities with regard to trans-sectional rehabilitation was undertaken in reference to a section in The Danish Reference Program for Hip Fracture (C. Jensen, Mainz, & Lamm, 2008). Focus was on organization, mobilization, objective assessments, training, and activities of daily living. Further, the leaders stressed reablement as a way to increase functioning and aged adults' ability to cope and manage without help. These basic pre-understandings made me want to hear the voices of aged adults suffering from a HF. Considering health to be more than the absence of disease, to have recovered well after HF could for aged adults be to reach a mode of being where possibilities for both activity and acceptance of life could be as they once had been.

Aiming to bring forward the perspective of aged adults, I initially conducted a systematic review of aged adults' experiences of self-efficacy and well-being (Rasmussen & Uhrenfeldt, 2016). The ontological insight from the review study helped me acquire a useful horizon for understanding the lifeworld of people, and the awareness of experiences of meaningfulness in human life as a resource. The epistemological insight was the knowledge gap of aged adults' experiences of being active. Based on these assumptions, the design of this PhD study was developed.

To secure application of research results among health care providers (HCP), a PhD-study reference group was formed consisting of representatives from the hospital and the four cooperating communities financing the study. This could, however, have led to seeing a continuation between the initiatives health care providers take and aged adults’ experiences, but my focus remained on the aged adults’ individual experiences.

2 Background

This thesis focuses on aged adults' lifeworld and refers to living with the short-term and long-term consequences of a HF. A HF is a serious condition that may radically change the preconditions for physical activity and thereby challenge the meaningfulness of being active. In this background section, I present five main aspects: The liminal state of ageing, HF consequences, HF rehabilitation, Experiences of recovering after HF, and physical activity. This leads to a summary and identification of the knowledge gaps that drive this study.

The liminal state of ageing

Ageing is described as a process that involves living in a changing lifeworld with health problems, an ongoing decrease of functioning and limitations of social life, a situation described to be a liminal state of frailty, and a disruption that changes a person's sense of identity (Nicholson, Meyer, Flatley, Holman, & Lowton, 2012). After a new illness incident, getting back to earlier rhythms of daily life and maintaining independency is vital and experienced to be hard work requiring an ongoing effort (Godfrey & Townsend, 2008). Frailty, fatigue, and social isolation threaten possibilities for being active in meaningful ways; however, coming to terms with the uncertain life situation is a possibility (Godfrey & Townsend, 2008). To feel recovered and capable of being active in this life situation, aged adults struggle to find a balance between loss and continuity (Nicholson et al., 2012). Although it takes longer to do things, it is experienced as being meaningful to do what one is able to do, and aged adults feel recovered when they find a new rhythm in life (Birkeland & Natvig, 2009). It is important for them to feel connected with the physical environment, and to remain active, aged adults create routines and maintain social networks (Nicholson et al., 2012). Continuously adjusting to the further deterioration of health, some aged adults find meaning in appreciating even small improvements, and particularly peer support and common experiences with other people provide a sense of purpose (Godfrey & Townsend, 2008). To maintain a sense of identity and feel at home in life when the awareness of life's finitude becomes apparent, attention is turned towards things that are important such as relationships. Feeling prevented from doing what they want to do, a sense of feeling recovered is possible by trying to be grateful, struggling to make the best of it, and taking one day at a time (Bullington, 2006).

Hip fracture

HF is a serious condition affecting the physical, mental, and social well-being of aged adults and brings a life situation with more disability than other osteoporotic fractures (Cummings & Melton, 2002), and it carries a 24.5% risk of dying within a year and 34.5% risk of dying within two years (Hu, Jiang, Shen, Tang, & Wang, 2012). All over the world, HF is a common fracture for people older than 65 years with osteoporosis (Johnell & Kanis, 2006). The world-wide incidence is predicted to increase from 1.6 million in 2000 to 6.26 million in 2050 (Cooper, Campion, & Melton III, 1992; Kanis et al., 2012). HF incidence rates in Scandinavia (Norway, Denmark, and Sweden) are among the highest in the world (Cauley, Chalhoub, Kassem, & Fuleihan, 2014). In Denmark, approximately 10,000 people with a mean age of 80 years suffer annually from a HF, and around 75% are women (Egerod et al., 2010). HF is related to osteoporosis (Bergstrom, Bjornstig, Stenlund, Jonsson, & Svensson, 2008; Marks, Allegrante, MacKenzie, & Lane, 2003), advanced age and frailty (Elffors, 1998; Ensrud et al., 2007; B. C. Taylor et al., 2004), and is more frequent among aged adults with a fear of falling (Pluijm et al., 2006; Tinetti, Speechley, & Ginter, 1988), and in lack of physical activity (Coupland, Wood, & Cooper, 1993; Hoidrup et al., 2001; Stel et al., 2004).

Consequences of a hip fracture

Loss of functioning and dependency after HF has a major impact on aged adults' well-being and possibilities for being active and may lead to anxiety and loss of social life (Peeters et al., 2016). Depressed mood and anxiety are a reality for approximately 30% of aged adults after HF, and they can affect recovery negatively (Lenze et al., 2007) and reduce physical and psychological well-being (Hallberg et al., 2004). Fear of falling, a condition that affects mobility and can lead to avoidance of activity (Jellesmark, Herling, Egerod, & Beyer, Dec 2012), is documented to be present in 63% of aged adults six months after HF (J. Visschedijk, Achterberg, Van Balen, & Hertogh, 2010). Pain is apparent for around 70% of aged adults three months after HF, and evidenced to be related to depressed mood and difficulties when independently managing activities in daily life (Herrick et al., 2004). Loss of functioning most severely affects aged adults' life during the first six months; however, the risk of chronic loss of functioning exists. Of 733 aged adults beyond six months and up to two and a half years after HF, only 31% regained their prior ability to manage daily life activities: 34% recovered their mobility, and 41% their ability to climb stairs (Tang et al., 2017). Even the ability to manage basic activities of daily living such as self-care and managing transportation was documented to be permanently lost for around 30% of aged adults with HF (Dyer et al., 2016). The above-described consequences were documented to be barriers for physical activity (Baert, Gorus, Mets, Geerts, & Bautmans, 2011; Franco et al., 2015).

The ability to be active after HF is most severely affected right after surgery and just around discharge from hospital (Peeters et al., 2016). The recovery period may be prolonged, and aged adults may experience that during the 18 months after HF they gradually reach a ceiling for how well they can recover. Progress in the ability to transfer and to walk seemed to level off around six months after HF (Alarcón, González-Montalvo, Gotor, Madero, & Otero, 2011; Magaziner et al., 2000). Hereafter, primarily the ability to bathe, dress, and climb stairs continuously improves up till one year. After one year, progress is still possible (Alarcón et al., 2011); it seems particularly possible to increase the number of social activities aged adults take part in until two years after HF. (Magaziner et al., 2000). Aged adults with pre-fracture limitations of functioning are evidenced to be particularly vulnerable to never recover to pre-fracture functioning and to experience diminished physical, mental, and social well-being (Aarden et al., 2017; Peeters et al., 2016; Tang et al., 2017).

Taking together, several factors can contribute to limiting aged adults' everyday life. However, there are shortcomings regarding knowledge on aged adults' everyday experiences of living with the consequences of a HF.

Rehabilitation after HF

Participation in rehabilitation after HF is vital and improves aged adults' possibilities for being active. A variety of rehabilitation programmes are evidenced to increase physical activity (Chudyk, Jutai, Petrella, & Speechley, 2009; Turunen et al., 2017); physical functioning and mobility (Chudyk et al., 2009; Handoll, Sherrington, & Mak, 2011; Wu, Zhu, & Zhang, 2018), reduce a fear of falling (Dukyoo, Juhee, & Lee, 2009), and improve self-efficacy (Chudyk et al., 2009; Dukyoo et al., 2009; J. H. M. Visschedijk, Caljouw, van Balen, Hertogh, & Achterberg, 2014), thereby promoting independent living. In-hospital rehabilitation after HF is described in guidelines focusing on mobilization strategies and the content and extent of rehabilitation programmes ((American Academy of Orthopaedic Surgeons, September 5, 2014; Chudyk et al., 2009; Mak, Cameron, & March, 2010; National Institute for Health and Clinical Excellence., 2011). The main part of rehabilitation takes place in the communities while aged adults are in their own homes or are living in rehabilitation centres (Handoll et al., 2011). Post-hospital guidelines for rehabilitation do not exist, but evidence is emerging that prolonged interventions in the communities including modification of the home, exercises, education, and social support increase the possibilities for being active after HF (Auais, Eilayyan, & Mayo, 2012; Resnick et al., 2007; Salpakoski et al., 2014; Turunen et al., 2017).

In Denmark, after following a fast-track in-hospital programme, aged adults are discharged home with a rehabilitation plan describing rehabilitation needs after discharge to be effectuated in the municipality (Kronborg, Bandholm, Kehlet, & Kristensen, 2015). Interventions include a re-ablement perspective focusing on independence and empowerment (Aspinal, Glasby, Rostgaard, Tuntland, & Westendorp, 2016), and possibilities for being active are supported by cost-free loan of aids and tools and tax-financed services, e.g. homecare serves to enable their activity at home (Description of rehabilitation efforts, 2010). Further, aiming to maintain aged adults' physical capability, social relations, and well-being, municipalities in Denmark offer follow-up rehabilitation, preventive home-visits on a regular basis, and partly or completely tax-financed activities at day-care centres (Vass, Avlund, Hendriksen, Holmberg, & Nielsen, 2006).

For aged adults, rehabilitation after HF concerns more than bodily functioning. The process of recovery is experienced to be a lonely process (Bruun-Olsen, Bergland, & Heiberg, 2018), and aged adults call for additional and better qualified rehabilitation, social support, encouragement from health care professionals (HCPs), and dialogue about the future (Bruun-Olsen et al., 2018; C. M. Jensen, Smith, Overgaard, Wiil, & Clemensen, 2017; Olsson, Nystrom, Karlsson, & Ekman, 2007; Stott-Eveneshen et al., 2017; Young & Resnick, 2009). Struggling to manage pain, side-effects from medicine, and limitation of physical functioning (Hallstrom, Elander, & Rooke, 2000; Olsson et al., 2007; Wykes, Pryor, & Jeeawody, 2009), aged adults depend on HCPs during rehabilitation to help them adjust to treatment and training (Rasmussen & Uhrenfeldt, 2016; Robinson, 1999). When cooperation and information are missing, they feel insecure about how to be active and worry about how recovery is possible (Rasmussen & Uhrenfeldt, 2016). Feeling unsafe and losing a sense of control and self-confidence, aged adults have existential concerns about the impact the HF has on their whole life situation (Olsson et al., 2007; Toscan, Manderson, Santi, & Stolee, 2013; Wykes et al., 2009). Despite rehabilitation, aged adults may experience that they do not recover well. Rehabilitation that aims to increase independency in aged adults focuses primarily on the promotion of physical functioning and to some degree on the psychological barriers for being active. Aged adults' concerns and how these influence their participation in physical activity are not explicitly addressed.

Aged adults' experiences of recovering after HF

Feeling limited by persistent dependency, pain, tiredness, and a fear of falling (Rasmussen & Uhrenfeldt, 2016) and the use of a lot of energy to manage basic activities of daily living, e.g. dressing and taking a shower (Jellesmark et al., Dec 2012), aged adults rely on help from HCPs and significant others to be able to manage (Bruun-Olsen et al., 2018; Dennett, Taylor, & Mulrain, 2012; Gesar, Baath, Hedin, & Hommel, 2017). Recovering from the HF, aged adults are evidenced to move from feeling content being dependent on help right after discharge from hospital towards later balancing a need for help while struggling to be as independent as possible (McMillan, Booth, Currie, & Howe, 2012; Robinson, 1999). Carefully planning what they are doing, relying on their own efforts to be active, and accepting decreased functioning and health deterioration as a natural part of becoming old seem to support a sense of being recovered (Bruun-Olsen et al., 2018; Gesar et al., 2017; Ziden, Wenestam, & Hansson-Scherman, 2008; Ziden, Scherman, & Wenestam, Jan 2010). Some aged adults seem to gradually come to terms with changed life conditions and reach a state of well-being in everyday life by feeling content and connected with other people, feeling self-confident and respected (Ziden et al., Jan 2010). However, while some aged adults maintain courage, others lose hope and a zest for life after one year (Rasmussen & Uhrenfeldt, 2016; Ziden et al., Jan 2010).

For aged adults not feeling recovered, the HF seems to be a disruption of their lives, and when unable to be active and socialize, they are feeling vulnerable and gloomy (Bruun-Olsen et al., 2018). With continuous fatigue, reduced physical strength and balance, and insecure about own physical capacity, aged adults may avoid going out, feel helpless and frustrated, and isolated from friends and family (Gesar, Hommel, Hedin, & Bååth, 2017; Jellesmark et al., Dec 2012). Not feeling recovered, aged adults regret being unable to be as active as they were before the HF and worry about becoming a burden to significant others (Rasmussen & Uhrenfeldt, 2016; Schiller et al., 2015) After one year, feeling helpless, disappointed, and sad that life has changed and how little they are able to manage, the trust and expectations for a better future are under pressure (Ziden et al., Jan 2010).

Physical activity

After HF, aged adults are evidenced to be very inactive (Zusman, Dawes, Edwards, & Ashe, 2018), and this may have consequences for their physical health and their well-being. Physical activity is evidenced to be vital, and for aged adults, a means of preventing diseases such as diabetes, cardiovascular diseases, and stroke (Lee et al., 2012; D. Taylor, 2014); preventing falls (Sherrington et al., 2008); slowing down decline in functioning; maintaining the ability to manage daily life activities; and increasing mental well-being, including a sense of satisfaction, optimism, and feeling in control (Tak, Kuiper, Chorus, & Hopman-Rock, 2013). The connection between good health and high levels of physical activity is highlighted, and World Health Organization (WHO)'s recommendations to reach specific levels of activity are recognized goals worldwide. However, the reality is that many aged adults are not able to reach the recommended minimum activity levels (Sun, Norman, & While, 2013). WHO describes physical activity to be not only exercising but also part of everyday life: household chores, walking, and playing (Oja & Titze, 2011; World Health Organization, 2010).

For aged adults, barriers for being active are complex and numerous and include a fear of falling, pain, fatigue, lack of self-confidence, and environmental factors such as feeling unsafe in the neighbourhood and when the weather is bad (Baert et al., 2011). Particularly for aged adults with poor health and dependency, it feels natural and part of ageing to be less active and avoid exhaustion (Franco et al., 2015). Social relationships, a major health-promoting factor, are vital and a meaningful context in which aged adults can be active (Holt-Lunstad, Smith, & Layton, 2010), and facilitators for being active have been shown to be obtaining better health, well-being experiences such as feeling optimism and self-confidence, the pleasure and joy from being active (Franco et al., 2015), and the physical environment, e.g. easy access to shops and senior centres, and senior-oriented activities (Moran et al., 2014).

Traditionally, interventions for aged adults living with disability or disease that focus on activities that increase endurance and stress behaviour change have had little effect (Brawley, Rejeski, & King, 2003). Recent evidence is emerging stressing the benefit from minor increments (de Souto Barreto, 2015; Sparling, Howard, Dunstan, & Owen, 2015) and the attention towards considering aged adults' experiences of meaningfulness in a daily-life context (Gebel, Ding, & Bauman, 2015; Hupin, Roche, & Edouard, 2015). A discourse overemphasizing efficacy, human agency, and individual responsibility for own health may lead to dogmatism and moralism (Scheel, Pedersen, & Rosenkrands, 2008). Changing the emphasis from health reasons and desired amount and intensity of physical activity towards the human element of being active is advocated when the aim is to help people to be more active (Puterbaugh, 2009). Humanistic approaches based on individual experiences are rich resources for guiding health-care providers in their quest to find ways to improve aged adults' possibilities for being active in ways that are desired and meaningful in human life as it is lived (Todres, 2008). Studies on existential barriers and facilitators for being active after HF are lacking.

A human perspective on health

From a human perspective, health is about more than physical health and the absence of disease (Karin, Nyström, & Dahlberg, 2007). Health has a hidden character and shows itself in a feeling of well-being, the taking for granted of the experience of being open to new things, and a general feeling of being involved in the world (H. Gadamer, 1996). Illness such as a HF disturbs aged adults' relationship with the world and the possibilities for being active in meaningful ways, and not feeling recovered represents a loss of freedom and exclusion from life. Recovering well after HF is related to experiencing well-being, feeling part of life, and being connected to other people in meaningful ways as well as feeling safe and free to participate in everyday activities that matter (H. Gadamer, 1996).

The dominant medical perspective of physical activity is considering inactivity as a main reason for ill health or a risky behaviour for people. In contrast, a focus in this thesis will be on how to improve an experience of well-being and feeling recovered as part of the search for knowledge on how to help people to be more active. Acknowledging physical activity to be subservient to people's needs, wishes, and desires (Puterbaugh, 2009), physical activity is addressed at an existential level. To understand the meaning of being active for aged adults with a HF is to gain insight into how aged adults live their life and feel recovered within complex life circumstances (Hemingway, 2011). Focusing on possibilities for well-being shifts attention from solely the body and independency towards possibilities in human life to find a way forward (Hemingway, 2011). Well-being is a resource in human life and a capacity that can create change towards being more active (Hemingway, 2011; Todres & Galvin, 2010). Exploring the existential experiences aged adults have in the long-term after HF can provide knowledge to guide HCP.

Identification of knowledge gaps

Knowledge gaps existing in the literature are addressed in this thesis. The consequences after HF can contribute to limiting aged adults' everyday life. However, there are gaps regarding knowledge about aged adults' everyday experiences of living with the consequences of a HF. After a HF, aged adults are sedentary, but little attention has been paid to understanding the perspective of aged adults regarding being active. Studies in aged adults on existential barriers and facilitators for being active after HF are lacking. During the 18 months after HF, aged adults seem to be struggling with physical, psychosocial, and existential challenges to feel recovered. The aim and scope of studies on experiences after HF are aged adults' concerns and experiences during rehabilitation, experiences of care, and experiences of recovery. Studies are missing on the existential perspective of the meaning of being active after HF. Only a few studies on experiences beyond six months after HF exist, aged adults' experiences beyond one year after HF are unexplored, and only one study followed aged adults over time, interviewing them at one month and one year after HF (Ziden et al., 2008; Ziden et al., Jan 2010). The meaning of events in human life change over time, and studies exploring changes and continuities following the same people during a longer period of time are lacking.

3 Aim and research question

The aim of this study is to explore and understand aged adults' experiences of meaningfulness of being active within the first 18 months after HF.

Research questions

An overall research question guided the study

What is the meaning of physical activity in the everyday life of aged adults after discharge from hospital and how may this change during a specific period after a HF?

Three additional research questions are explored in the following three papers:

Paper 1: **"Being active after hip fracture: older people's lived experiences of facilitators and barriers":**

Research question: What are facilitators and barriers for being active experienced by aged adults during the first six months after hip fracture surgery?

Paper 2: **"Aged adults' everyday life experiences of being active one year after HF"**

Research question: What are aged adults everyday life experiences of being active one year after HF taking an existential perspective?

Paper 3: **"Being active 1½ years after hip fracture aged adults' experiences of meaningfulness, a qualitative interview study":**

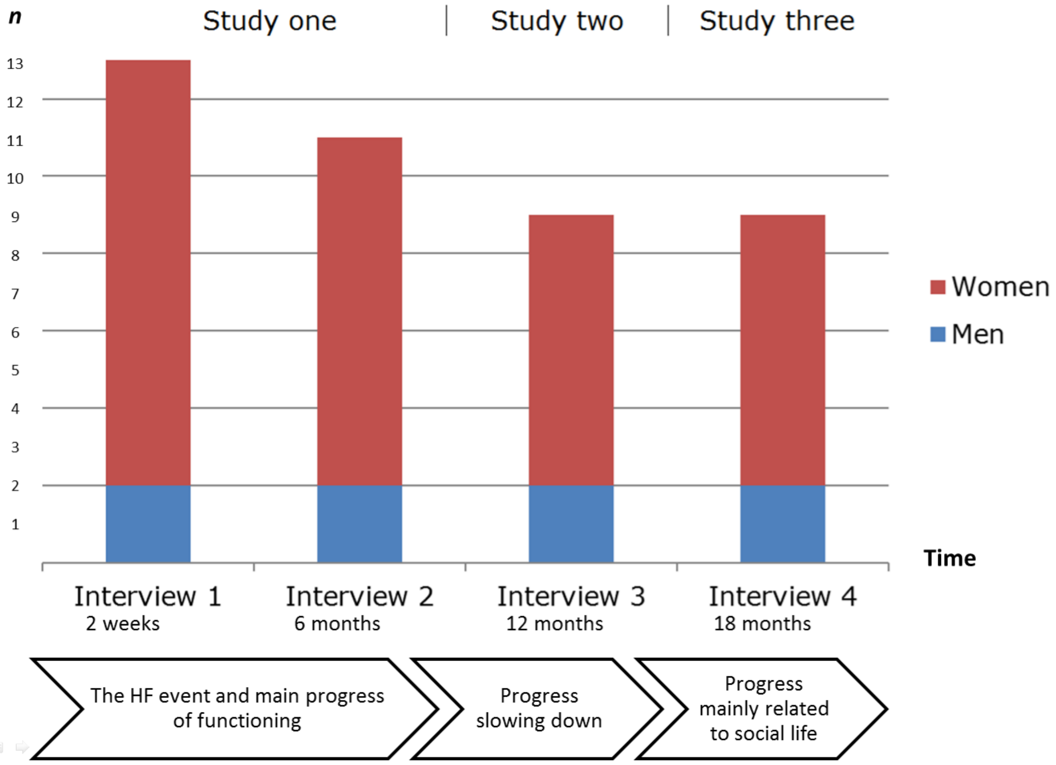
Research question: What are aged adults' everyday life experiences of the meaningfulness of being active 18 months after a HF?

4 The research design

To capture how the meaning of being active may change through the recovery process, a phenomenological-hermeneutic approach based on the existential philosophies of Martin Heidegger (1889–1976) and Hans-Georg Gadamer (1900–2002) was chosen to explore the human experience as it is lived while implementing interpretation as an inevitable part of understanding.

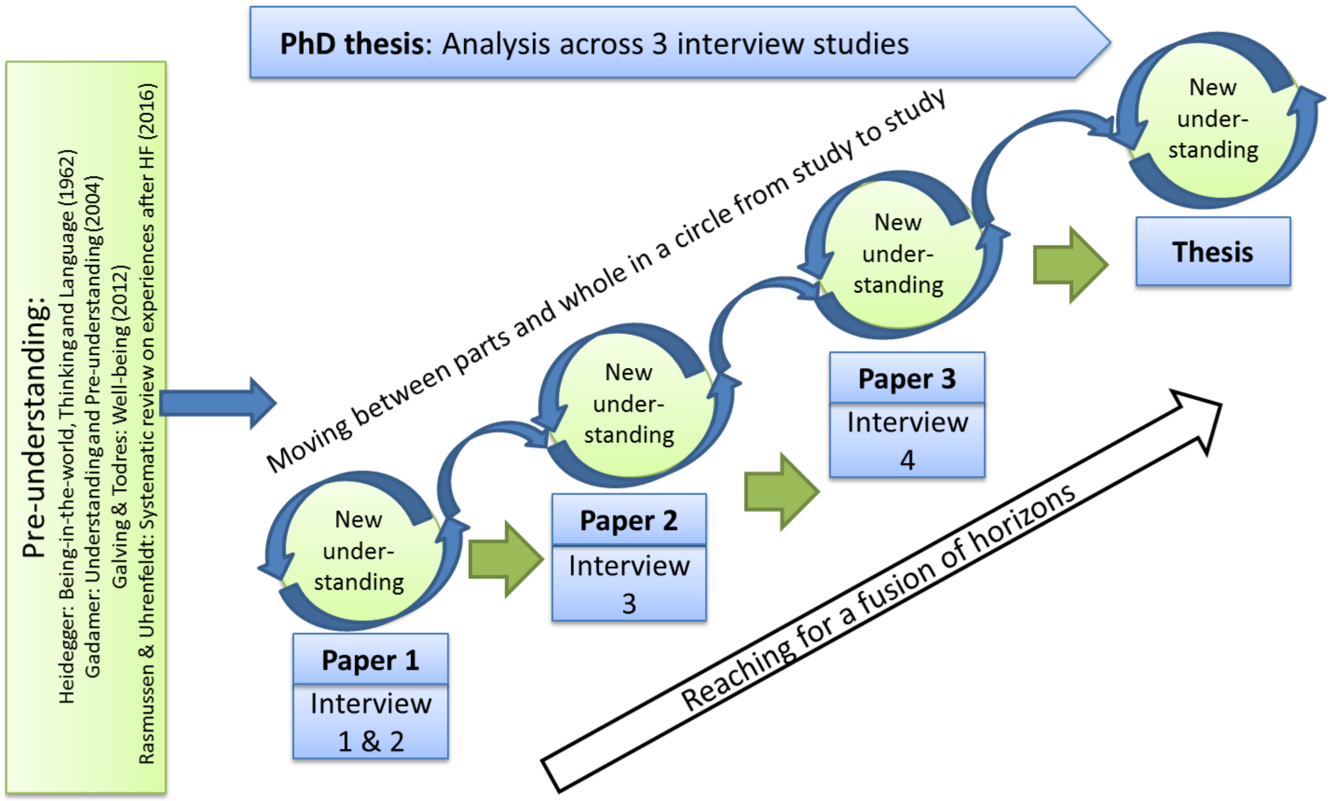
To capture experiences of being active with a HF at different time points and to follow changing experiences over time, a longitudinal design was chosen. The same participants were followed during approximately 18 months after discharge from hospital after a HF (Figure 1). The disease trajectory after HF was used to organize four interview rounds half a year apart, resulting in three sub-studies (Sandelowski, 1999). The first interview was shortly after discharge from hospital when dependency was the highest and functioning the lowest; subsequent interviews were time points at which plateaus of recovery of functioning seem to be reached: six months, one year, and 18 months.

Figure 1 Longitudinal design and number of participants at four interviews



The research design presented in Figure 2 gives an overview of the path taken and how the longitudinal design was the structure that allowed for a stepwise wider horizon of the researcher to evolve, and supported the timely process of reaching a new understanding. To the left in the figure, the pre-understanding was the theoretical and methodological influence from Heidegger (1962), Gadamer (2013), and Galvin & Todres (2012), and the systematic review on aged adults' experiences after HF conducted prior to designing the PhD study (Rasmussen & Uhrenfeldt, 2016). Moving between the parts and the wholes within each study and between all studies through a hermeneutical circling from the left to the upper right corner illustrated how a deeper understanding of aged adults' experiences of being active after HF was reached. The design made it possible to explore aged adults' experiences at various time points when specific conditions with respect to the healing process seemed to be prevalent. In each study, main themes and sub-themes were developed and became part of a new understanding. In this thesis participants' individual development, change, and continuity as well as the search for patterns across all the studies to reach a new understanding are discussed.

Figure 2 The hermeneutical circle in a longitudinal design leading to new evidence



5 Methodology and methods

In this chapter I elaborate on the theoretical framework, the philosophical and methodological context for the thesis, the methods applied and ethical considerations.

Theoretical framework

This section is an elaboration on the main theoretical pre-understanding influencing the study. The main influence was from the philosophers Martin Heidegger and from a theoretical framework developed by nursing scholar Kathleen Galvin and psychologist Les Todres. Heidegger's philosophy through his ideas on being-in-the-world was influential with regard to the understanding of meaningfulness in human life. Galvin & Todres' existential theories of well-being and suffering were useful in understanding the wholeness of aged adults` experiences within interrelated dimensions of meaning.

A being-in-the-world approach

Heidegger (1962) was interested in how it was possible to understand the being of human beings. He used the expressions being-in-the-world to describe the lifeworld as a state we could not escape; it is a whole, and our human being and life were influenced by and influenced the world and other human beings (Heidegger, 1962). The expression da-sein (being-there) expressed how aged adults' in a concrete, factual everyday life always already understood their own being as a unitary phenomenon (Heidegger, 1962). Being "thrown" into the world (Heidegger, 1962 p 231), aged adults had a sense of feeling at home and a sense of permanence and stability. The past, presence, and future were a continuous whole; having been and lived in the past released into the present, from which the possibilities for being active in future were grasped or impossible to grasp (Morse & Field, 1995). However, according to Heidegger (1962), there was always more to life (Heidegger, 1962). Change, unpredictability, and possibilities represented a life condition, and when the familiarity of being active in everyday-life for aged adult was challenged, they had the potential to develop and take independent decisions to change the lifeworld and improve their lives (Heidegger, 1962). For Heidegger (1962), experiences in the lifeworld of aged adults could only be understood as part of the lifeworld of other people, an experience of being concerned and caring about others, doing things for others, or being disregarded and passed by (Heidegger, 1962).

To understand meaningfulness according to Heidegger (1971) was to sincerely understand the ontological possibilities for being active experienced within the ontic realities of everyday life, where we as human beings were living and experiencing our being in a togetherness with the concept of the four-fold. This four-fold human existential condition Heidegger described as: "the earth", symbolizing the natural world, i.e. the ageing body, and personal beliefs; "the sky", illustrating the unknown and changing times; "the divinities", a longing or hope beyond rationality; and "the mortals", representing human being-towards-death (Heidegger, 1971a p 147-148). Heidegger considered concern to be a fundamental human trait. For aged adults the anxious effort, i.e. dedication to shaping, creating, being thoughtful, and thinking about their own being and actions (Heidegger, 1962), may be a concern when a HF brought death up close as the end of a future and end of hopes and possibilities for being active.

A theoretical framework of well-being

From the lifeworld perspective, a HF was an integrated part of aged adults’ life situation and the experiences they had of being active. A theoretical framework developed by Galvin & Todres (2012) building on Heidegger’s ideas of being-in-the-world was chosen to expand ideas about meaningfulness as an intertwined experience of well-being and suffering rather than experiences of specific purposes and intentions, thereby providing insight into aged adults’ possibilities, preferences, and goals. Health was considered to be more than the absence of disease, and a good life to be possible also during illness and when living with disabilities, i.e. after a HF (K. Galvin & Todres, 2012).

Todres & Galvin describe well-being at its deepest core to be characterized as a unity of dwelling and mobility (Todres & Galvin, 2010). Well-being was a resource to be considered in human life, and a capacity that could create change towards being more active. However, well-being was always to be understood in relation to suffering. To care for other people was to understand their suffering and the vulnerability it announced as well as their possible freedom. Dwelling in life was groundedness in each moment allowing for whatever was there to be and a feeling of being at peace. Mobility in life was a kind of restless calling of possibilities, which carried a sense of energy and vitality (Todres & Galvin, 2010). Mobility in life could be conceptualized as homelessness, an experience of the disturbance of the taken for granted security of feeling at home in our life and with our self. This could be a call to move towards homecoming. Coming and being at home was a sense of well-being that could be felt as openness towards changes in one´s personal life, embracing the existential vulnerability of being human and being present in the moment (Todres & Galvin, 2010). Different nuances of wellbeing and suffering could be experienced in embodied, spatial, temporal and inter-subjective ways, and in terms of mood and identity (K. Galvin & Todres, 2012). Each of these facets stood out and was experienced in the fleeting moment in varying degree as a figure or as the background, all present at the same time and more or less the focus of experiences (K. T. Galvin & Todres, 2011).

Understanding and pre-understanding

The purpose of this section is to elaborate on the philosophical context for the thesis. The main influence is from the philosophers Martin Heidegger (1889-1976) and Hans-Georg Gadamer (1900-2002) whose thoughts on understanding and pre-understanding are relevant for the methods used.

Interpretation

Martin Heidegger was a student of Edmond Husserl, the founder of phenomenology, and developed phenomenology into also being hermeneutic (Morse & Field, 1995), and Gadamer building on Heidegger`s thinking further developed the ideas of understanding and interpretation. Heidegger (Heidegger, 1962) rejected Husserl’s idea that the lifeworld could be rationally understood in a subject-object relationship, where suspending all pre-suppositions in the study of phenomenon secured valid data (McConnell 2009). For Heidegger, understanding was interpretation and a way of being-in-the-world (Heidegger, 1962). The world was already understood, the past and culture were part of our understanding and could not be eliminated (Heidegger, 1962). The ideal of research thereby shifted from seeking the correct understanding of lived experiences free of the influence from context and pre-understandings to acknowledging that understanding arose from interpretation of meaning in human life (Laverty, 2003). Gadamer (1988) secured that the focus of the researcher changed towards the point of view in the text and in what a person was talking about. Understanding arose from the sharing of opinions, the sharing of meaning, not from transposing oneself into the inner life of another person (H. Gadamer, 1988).

For Heidegger, interpretation was based on understanding and not the other way around (Heidegger, 1962). What was first understood, projected possibilities, and possibilities were developed by interpretation. In this study, understanding developed over time within a frame of relevance, and the working out of possibilities (Heidegger, 1962) was the physiotherapist's focus on promotion of aged adults functioning after HF and healthcare practice in hospital and municipalities aiming to improve aged adults' possibilities for independency after HF. Fore-having, fore-sight, and fore-conception were considered part of the interpretative process that should be worked out to prevent understanding from becoming a vicious circle of repeating common or standardized notions of the phenomenon (Heidegger, 1962). Fore-having was what was already understood, though not completely, i.e. the contextual setting and the prior knowledge on HF, physical activity, and aged adults' experiences worked out in the introduction and the background of this thesis. The fore-having according to Heidegger fixed the sight on something, and this was the frame within which it was understood in the first place, i.e. the aim and research questions developed for doing this study. The fore-conception Heidegger described as what was grasped in advance, i.e. the theoretical framework and existential perspective used in this study. Interpretation thereby in this study was to be involved in a practice of striving to bring prior understanding into the open in the present and working out possibilities to develop a new and larger understanding of something. Although pre-understanding was not completely understood, circumspection (Heidegger, 1962), space, and sufficient time to dwell with data assured a process of by-passing own pre-understanding so that interpretation could occur (Smythe, Ironside, Sims, Swenson, & Spence, 2008).

Thinking and language

Heidegger stated that "language is the house of being" (Heidegger, 1977 p 237).Thinking was a vessel to make the being of human beings visible, while language was a mediator of thinking, expressing, and unfolding the being of human beings. Language in this thesis was a medium that allowed the understanding of human life and revealed the ontological possibilities of human beings. Heidegger wrote: "And so it is proper to think the essence of language from its correspondence to being and indeed as this correspondence, that is, as the home of man's essence" (Heidegger, 1977 p 231). When we and the participants in the study spoke, we expressed our being-in-the-world as the unified experience it inevitably was (Heidegger, 1962). As a researcher, I understood what was heard or read because of a common historical background or basic understanding about the subject and because of our common existential conditions for being-in-the-world. For Heidegger, silence was not empty, it was full of answers: "Hearing and keeping silent were possibilities belonging to discursive speech" (Heidegger, 1962 p 204). Hearing and reading in this study not only addressed the objective words but were also about listening and allowing things to show themselves as they were in themselves, i.e. to hear a meaning behind the words (Heidegger, 1962). To understand a person was to let the person be preserved as a whole, to embrace it in its essence, which meant "to love it, to favour it" (Heidegger, 1977 p. 196), thereby giving the person priority over my own prejudices.

Understanding and making sense of human experience was a process of thinking, which was different from the thinking that was concerned with connections and usefulness, which were pre-understandings that should be considered (Heidegger, 1977). For Heidegger (1977) thinking was a fundamental structure belonging to the being of human beings not detached from what it was thinking about (Heidegger, 1977), and phenomenological-hermeneutic research required me as a researcher to move between being a researcher investigating the phenomenon under study and being a human who was thinking about own pre-understandings (Smythe et al., 2008). Thinking was to listen without specific goals or intentions. Thinking took time and was connected with dwelling, which Heidegger illustrated as building a house where dwelling can occur, pointing out the necessity of creating the right conditions for thinking and staying with things to allow meaning to occur (Heidegger, 1971a).

Interpretation and a fusion of horizons

Gadamer's elaboration of a philosophical hermeneutics offered valuable insights into how a deep understanding based on interpretation could be developed. He did not detail a step-by-step method, but general principles (Brinkman & Kvale, 2015), which in this thesis guided the analysis of interview transcripts. Gadamer placed human experience in a relationship with history, denoting how we could not escape our experiences and look at things objectively (Fleming, Gaidys, & Robb, 2003). Understanding was situated within a larger historical horizon of the text and of the reader, where new meaning evolved in the fusion of the horizons of the one and the other (H. Gadamer, 2013). What was viewed and understood in a situation depended on the horizon of the researcher. Without a useful horizon the researcher may not see far enough and overvalue what was nearest. To have a useful horizon enabled the researcher to see what was beyond a situation in this study. This effort to develop a useful horizon was worked on continuously throughout the writing of thesis, i.e. in the introduction, the background section, and the methodology section. A fusion of horizons was advanced through the understanding of a text on its own terms, as well as relating it to the meaning for the reader (H. Gadamer, 2013). This involved bridging the gap between what was familiar and what was unfamiliar and allowing the otherness to present itself, thereby adding surprising, new meaning and knowledge (H. Gadamer, 1988). Presupposing openness, a fusion of horizons, was reached for through the hermeneutical circle in a step-wise appropriation of what was essential in the text, allowing prejudices to be continuously tested (H. Gadamer, 1988). In a circular movement between the whole and the parts, the understanding of the unity of the text was expanded centrifugally (H. Gadamer, 2013). Research questions and interview questions were the structure that put the prejudices at risk by essentially opening up possibilities and keeping them open (H. Gadamer, 2013). The fusion of horizon was never completed but realized in its fullest potential when the relevance and usefulness of study results seemed to be completed in a unity of meaning (Debesay, Nåden, & Slettebø, 2008).

Aiming to access the ontological structure of aged adults' experiences, openness was applied during preparing for interviewing and collecting data (H. Gadamer, 2013). The interview situation was regarded as a living situation of being-with (Todres, 2008), bringing myself to the situation. A relational bonding was sought to bring the possibility of talking about situations and experiences from the lifeworld that were significant for the individual and not just an intellectual abstraction. Openness was a way of being, a felt willingness to listen and understand, to be sensitive and remain willing to be surprised (H. Gadamer, 2013), while constantly bearing in mind to keep focus on knowing more about interviewees' experiences of being active (Karin et al., 2007). With a curious naivety (Brinkman & Kvale, 2015), the attention during the interviews was on what the aged adults were relating, avoiding taking over the conversation and allowing them to freely talk about their everyday lives and experiences that were important for them.

Participants and settings

Based on the literature review of current evidence presented in the background section, inclusion criteria (Table 1) were developed to purposefully include aged adults who were most likely to experience that their lifeworld was permanently changed by the HF (Sandelowski, 1999). Participants were selected at the start of the study according to the criteria listed in Table (Coyne, 1997).

Table 1 Inclusion and exclusion criteria

Inclusion	• Hip fracture surgery • Older than 65 years. • Limitation of functional ability prior to HF: Dependency on help or on walking aids Community living • Able to talk about the HF experience
Exclusion	• Fracture other than HF • Discharged to permanent nursing home living

Aged adults were included during their stay at Horsens Regional Hospital. The communities were a blend of provincial towns, villages, and rural areas. The hospital had acute, elective, and ambulant treatment and was one of five hospitals undertaking HF surgery in Central Denmark Region of Denmark. Inclusion started in March 2015 and was slow due to a period where few people were admitted with HF and many of these people did not meet the inclusion criteria (Table 1). This gave raise to considerations regarding whether the completion of the study within the three-year period was at risk. Therefore, Viborg Regional Hospital, a hospital of similar size and admission area, was contacted and agreed to include patients, and inclusion was final in July 2015. The gatekeepers who selected participants for inclusion were physiotherapists and occupational therapists employed at the hospital attending patients at the orthopaedic department who had been introduced to the study orally and in writing (appendix A). Based on an occasion where a participant was judged to be fragile and not asked about inclusion, I talked with the gatekeepers about overprotectiveness and the possible benefits from being part of an interview study (Dempsey, Dowling, Larkin, & Murphy, 2016).

Thirteen women and two men were included consecutively after HF surgery (see Figure 1). Participants were from all the communities (*n*=8) receiving discharged patients from the two hospitals. At the time of inclusion, participants were between 70 and 92 years old. The two men and one woman lived with their spouse; one woman lived with son and daughter in law, while the others lived alone. All participants during the interviews referred to diseases other than the HF. Drop out was due to death (*n*=3) and a difficult mental situation (*n*=1). Please see Table 2 for details.

Table 2 Overview of participants

Code name & age	Pre-fracture walking aid & need of help	Other (known) diseases than actual HF	Housing conditions	Interviews & context; dropout
Dorthe 73	Walker outdoor. Cleaning, medicine dosage	Stroke	Older-friendly housing	1st-4th: own home
Hannah 77	Walker outdoor	Almost blind, injured nerve in leg	Villa	1st: rehab centre 2nd: own home 3rd: dropout (died)
Ingrid 77	Walker Cleaning	Heart attack, paralysis	Villa. Living with spouse	1st: own home 2nd: dropout (died)
Bodil 78	Walker Taking a shower, cleaning, laundry, medicine dosage	Stroke, heart attack, kidney problems	Living with son and daughter-in-law in the countryside	1st-4th: own home
Karen 80	Walker Shopping	Parkinsonism, contra-lateral HF	Ground level flat	1st-4th: own home
Margrete 80	Walker outdoor	Stroke, migraine	1st-3rd int.: Apartment, 6 steps up 4th int.: nursing home	1st-3rd: own home 4th: new residence
Anna 85	Walker Putting on compression stockings	Gout. Dizziness.	Older-friendly housing	1st: own home 2nd: Short-term room in nursing home 3rd: dropout (died)
Joan 85	Walker outdoor away from the house Visits for security, cleaning	Contralateral HF	Villa	1st-4th: own home
Nelly 89	Furniture support, walker or support from a person outdoor Medicine dosage, cooking, cleaning, shopping	Diabetes, almost blind	Apartment, 6 steps up	1st: own home 2nd: dropout due to mental difficult situation
Lene 90	Walker outdoor Cleaning	Chronic obstructive lung disease	Older-friendly housing	1st-4th: own home

Else 92	Walker Cleaning, laundry, medicine dosage	Diabetes, almost blind	Villa	1st: rehab centre 2nd – 4th: own home
Frank 70	Wheelchair, walker, four-point cane Transferring, personal hygiene, dressing (socks). Wife manages the house	Stroke, cancer	1st – 2nd int.: Villa. Living with spouse 3rd-4th int.: apartment adjacent to nursing home	1st: day care centre 2nd: own home 3rd-4th: new residence
Gunnar 77	Walker, support from wife Verbal guiding when transferring. Wife manages the house	Stroke, 6 times herniated disc, spinal stenosis	Villa. Living with spouse	1st: rehab centre 2nd-4th: own home

Data collection

The first interview round began in March 2016 and was conducted approximately two weeks after discharged from hospital. The last interview was completed in March 2018. Preparing for the interviews, a semi-structured interview-guide was developed for each interview round (Appendix B) based on the literature review, the theoretical framework, and on the previous interview round (Brinkman & Kvale, 2015). During all interviews, open-ended questions were used to give participants the opportunity to talk freely about what was important for them to share. During the four interview rounds, an increasingly open lifeworld approach was applied. For example, replacing questions such as "What makes you feel like being active" with questions like "When do you feel comfortable"; and shifting between questions referring to concepts and questions, inviting to talk about situations. Open questions being answered naturally led to follow-up questions, silence, nodding, and repeating words to encourage participants to elaborate on their statements (Brinkman & Kvale, 2015). Follow-up questions could be, "Can you please tell me what that means to you" or "could you give an example". Interviews lasted between 32 and 119 minutes. The 2nd and 3rd follow-up interviews tended to be longest in all participants (Table 3).

Table 3 Duration of interviews

Interview number	Duration ranging from and to
1st	34–84 minutes
2nd	51–119 minutes
3rd	35–130 minutes
4th	32–79 minutes

Being in familiar surroundings was preferred to allow participants to feel more relaxed, and to inspire talking about their daily lives (Brinkmann, 2013). Participants allowed the interviews to take place in their homes or, at first interview for some, in the rehabilitation centre where they were staying (Table 2), thereby offering the possibility to understand more about their being, noticing how they moved about, and where and how they sat, the things they showed, and the places they spoke about in their close vicinity (Heidegger, 1971b). For example, participants occasionally directed attention towards the outdoor surroundings, showed photos, books, or the assistive devices they used. Also, the tone of their voices and pauses when speaking were noticed. These impressions together with the immediate understanding of what they were talking about were noted immediately after the interview (Brinkmann, 2013).

At follow-up interviews, participants had a more familiar tone; started talking before the tape recorder had started; or after the interview they invited me to share everyday experiences, e.g. showing photos or a preferred view from a kitchen window. Benefitting from being more familiar with participants in the follow-up interviews, different strategies to bring forward their own personal stories were possible to apply. For example, experiences from interviewing participants of few words, being a challenge to keep the conversation moving forward, I was prepared for the need to ask a lot of questions. Being aware that disparity is obligatory in research interviews; to avoid an interrogative atmosphere during these interview, I chose once in a while to talk about my own life (Karin et al., 2007), to address neutral subjects, e.g. about the coffee we were drinking, or my trip to their homes (Price, 2002), and to express gratitude for their contributions (Kirkevold & Bergland, 2007). Reformulation of what they had said in answer to a question was used to further elaboration on the topic. Some participants displayed discomfort when urged to expand on experiences regarding the meaning of something or when expressing feelings. To establish a more relaxed atmosphere, I would shift between easy to answer questions that emphasized actions (e.g. "what did you do next?") and more difficult, value-oriented questions (e.g.: "what did it mean to you?") (Price, 2002). In contrast, one participant preferred talking about experiences as an on-going, uninterrupted story; the researcher trusted the participant to make a point even when straying into peripheral topics (Karin et al., 2007), and questions were posed that aimed at deepening the understanding of the participant's values and beliefs (Price, 2002). When occasionally using direct questions, I paid close attentions to tone of voice and body language to support judgement and reasonable doubt (Karin et al., 2007).

Relatives were present at the first interviews on some occasions. A son who was present during the first interview did not enter the dialogue on his own initiative, but his mother (Joan) now and then turned to the son for confirmation, which urged him to make encouraging remarks to Joan, who had lately experienced great personal losses. A wife presented herself as the gatekeeper for the participant (Gunnar), who had memory problems and talked in short sentences after a previous stroke and was present during all interviews. She occasionally corrected what was said; primarily when Gunnar looked at her, in doubt about some facts he wanted to share. Increasingly during the four interviews, she expanded on Gunnar's accounts or encouraged him to tell about specific episodes. Another wife joined the 2nd interview after approximately 20 minutes. The participant (Frank) tended to express himself briefly about his present situation, and the wife wanted to supplement his account with specific information about their common situation and plans. Accounts that were not supplements of the participants' own story was fused with the researcher's horizon and were useful to reach for understanding of the relevance of Frank's accounts of episodes in his life but were not included when selecting units for data analysis.

Ethical considerations

The study was registered in the Central Denmark Regional Research Council journal no. 1-16-02-422-15 (Appendix C). Assigning a pseudonym to each participant and the dissemination of participants across eight municipalities secured anonymization, and to protect personal data were stored behind double locked doors. Responding to ethical principles of information, voluntariness, and informed consent as described in the Declaration of Helsinki (World Medical, 2013), physiotherapists and occupational therapists at the orthopaedic department along with informing about the study delivered information sheets (appendix D) and obtained written consent from patients (appendix E). Gatekeepers were beforehand informed about the study and instructed that their assignment was to protect HF patients from being urged too consistently from my eagerness.

Informal steps to secure ethical conduct were through the awareness towards participants' sense of dignity and well-being (Fog, 1998). Participants, except in one case due to early discharge, were contacted by me prior to discharge to give them the possibility to ask for additional information. The interview started with a dialogue about the purpose of the study. Prior to each interview, anonymization and the possibility to withdraw from the study were reconfirmed. During the interviews, I applied discernment based on my own past experiences from being with aged adults in clinical and private situations. This included an embodied know-how of attuning myself to recognize participants’ signs of discomfort or aversion (Angel, 2013). Doing a longitudinal study and becoming more familiar with participants’ special awareness was directed towards staying focused on the interview topic, avoiding becoming too empathetic, or appealing to revealing more that they wanted (Fog 1998). Recognizing the vulnerability of participants, I expressed my gratitude for their sharing of their experiences with me during or after each interview to acknowledge their contribution (Orb, Eisenhauer, & Wynaden, 2001). After each interview, time was spent talking about the experience of being interviewed (Brinkman & Kvale, 2015).

A general ethical concern was the study's contribution with knowledge of a vulnerable group of aged adults (Orb et al., 2001). In a single case, a participant spoke repeatedly about lacking an assistive device which prevented her from walking in the garden; it was judged to be ethically correct after permission from the participant to talk with a healthcare provider about her problem.

Data analysis

To remain in the open and avoid too hasty conclusions, an analytical five-step process of meaning condensation was applied (Brinkman & Kvale, 2015). The interpretation was not only stepwise, but a practical supportive measure to work on pre-understandings. A horizontal and vertical movement through data at each step of analysis secured an on-going circular movement between the parts and the whole of each interview and of all interviews (H. Gadamer, 2013), thereby staying faithful towards participants’ being-in-the-world. This supported a progression of thoughts and an on-going dialogue with the data. When in doubt about how or whether participants’ experiences had changed, former interviews and the researcher’s interview notes were re-read. The circular movement between one interview round and earlier interviews expanded the understanding of what was said within a new whole of continuously learning more about the participants' lives in the flow of time, transmitting experiences between the past and the present (H. Gadamer, 2013).

Firstly, all interviews were transcribed verbatim, listened to, and read several times. This was the researcher's first step of remaining open towards the current horizon of the participant, securing their historical accounts. Secondly, natural meaning units from each interview were selected and condensed into briefer statements. Selecting the meaning units was done by questioning the text with regard to whether the units expressed experiences related to the aim (Brinkman & Kvale, 2015) and avoiding meaning units where relatives' experiences were confused with participants' own experiences. The condensation was a means of staying close to participants' own words, reaching a deeper understanding without applying a theory of understanding. Thirdly, condensed meaning units were rewritten into a more abstract description of the underlying meaning. Encounters were presented so they appeared sound and coherent; and considering the whole of the participant, the researcher applied judgment to achieve the correct understanding when contradictions, errors, or inconsistencies appeared (Debesay et al., 2008). Fourthly, data were interpreted in relation to the research question, seeking the meaning the data had for the individual, securing close relation to data by mixing participants' own words with more abstract terms (Smythe et al., 2008). Fifthly, the essential meaning of what was significant to the participant was written into non-redundant sub-themes and themes (Brinkman & Kvale, 2015). The in-depth descriptions were based on extensive interpretation and theoretical analysis (Brinkman & Kvale, 2015). Selected excerpts from participants illustrated the connection between themes and lived experiences (Sandelowski, 1994). Interpretations questioned in discussions and reflections with co-authors led to new insights and further depth in the analysis and supported credibility and dependability.

6 Findings

In this chapter findings are presented in the form of three papers.

Paper 1: Being active after hip fracture; older people's lived experiences of facilitators and barriers *(Accepted)*[1]

Paper 2: Aged adults' everyday life experiences of being active one year after hip fracture *(In draft)*

Paper 3: Being active 1½ years after hip fracture; aged adults' experiences of meaningfulness, a qualitative interview study *(In draft)*

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[1] Accepted 26th Nov for publication in International Journal of Qualitative Studies in Health & Well-being

Paper 1

Being active after hip fracture; older people´ lived experiences of facilitators and barriers (In press, Nov 2018)

Birgit Rasmussen, Claus Vinther Nielsen & Lisbeth Uhrenfeldt

Abstract

Hip fracture (HF) incidents can severely restrict the activity and well-being of older people, particularly for those who prior to HF have limitations of their functioning. While participation in activities may be related to lived experiences of meaningfulness, the aim of this study was to explore facilitators and barriers for being active as experienced by older people the first six months after HF. Using a phenomenological-hermeneutic methodology informed by the philosophies of Heidegger and Gadamer, participants older than 65 years who prior to the HF had reduced functioning were interviewed two weeks (*n*=13) and again six months (*n*=11) after discharge using a semi-structured interview guide. Referring to an existential theoretical framework of well-being, a method of meaning condensation was used to structure the data. A deeper understanding was gradually achieved through a movement between the parts and the wholes and between pre-understanding and new understanding. The study was registered in the Central Denmark Regional Research Council jr. nr. 1-16-02-422-15. Two categories emerged; 1) "Inner dialogue and actions" with the subcategories "Inner driving forces" and "Inner limitations and 2) "Struggling and Striving" with the subcategories "Building relationships" and "Considering complications and conditions". We conclude that facilitators for older people to experience well-being while being active involve meaningful relationships with other people, a sense of own identity and being at peace. These inner driving forces may be influenced by relationships with staff, physical surroundings, public health services and health problems; therefore, attention is needed towards a split between older people´s wishes and their abilities and possibilities.

Key words

Barriers, facilitators, hip fracture, activity, meaningfulness, well-being, aged adults, qualitative, community, rehabilitation

Introduction

Older people´s lived experiences

Older people´s lived experiences hold valuable knowledge about facilitators and barriers for being an active part of their being-in-the-world (Heidegger, 1962) after a hip fracture (HF). Their experiences are holistic and complex, expressing the meaningfulness of being active in the practical everyday life full of interrelationships (Dahlberg, Todres, & Galvin, 2009), and the interdependence of older people and the surrounding world (Heidegger, 1962) implies that after a HF, they are active in a world that is familiar in its everydayness while caring about their future, other people and their physical surroundings. They not only rationally divide experiences into physical, emotional, and social categories, but think freely in a unified experience of meaning. Focusing on the life-world, a good life is possible also during illness. This study uses a theoretical framework developed by Todres and Galvin. Inspired by Heidegger's writings they describe health as an existential experience of well-being, which at its deepest core is a felt unity of dwelling and mobility (Todres & Galvin, 2010). Dwelling is feeling grounded in the present moment allowing for whatever is there to be; whereas mobility is a kind of restless calling of possibilities, carrying a sense of energy and vitality (K. T. Galvin & Todres, 2011). However, a basic condition of human life is that experiences of well-being exist intertwined with experiences of suffering. Existential suffering can be an experience of being exiled, imprisoned, and unable (Todres & Galvin, 2010), a feeling of anxiety and homelessness in one´s own life, which may be present when illness occurs. This can be a call for action and bring mobility to life as a positive experience, felt as openness towards changes in life while aiming for home-coming to a sense of own identity and an experience of belonging.

Hip fractures

HF is a sudden traumatic experience from which 40-60% of older people with pre-fracture mobility restrictions never recover {{980 Dyer, Suzanne M 2016}}. They seemingly live an inactive life in hospital, during rehabilitation, and still six months after discharge (Davenport et al., 2014; Fleig et al., 2016; Peiris, Taylor, & Shields, 2013; Resnick et al., 2011), which could potentially pose a threat to their well-being and maintenance of physical and mental capacities (Lee et al., 2012; World Health Organization, 2010). A hospital stay likely to be short aims to accelerate older people´s mobility after HF (Giannoulis, Calori, & Giannoudis, 2016) in a fast-track program (Kristensen & Kehlet, 2012) and by post-discharge community based rehabilitation in their own home or in a rehabilitation center (Handoll, Sherrington, & Mak, 2011). Still, six months after HF older people may experience that possibilities for being active are limited when progress is slowing down or ending and loss of functioning still prevail (Ortiz-Alonso et al., 2012).

In Denmark, possibilities for being active after HF is supported by tax-financed public services including a rehabilitation plan (Kronborg, Bandholm, Kehlet, & Kristensen, 2015) implemented in the municipalities after discharge; access to cost-free loans for aids e.g. a single walker; and modifications in the home such as ramps over doorsteps (Description of rehabilitation efforts, 2010). Further, aiming to maintain older people´s physical capability, social relations and well-being, municipalities in Denmark offer partly or completely tax-financed activities at for example day-care centers. However, to our knowledge no studies investigated older people´s experiences of their well-being and possibilities for being active after HF within this context.

Being active after HF: barriers and facilitators

During hospitalization with HF, older people´s experiences of barriers for being active may be connected with frequency and severity of symptoms such as pain and weakness and when they need help and staff is missing, they do not ask for help (Brown, Williams, Woodby, Davis, & Allman, 2007). When vulnerability is not acknowledged by the staff, this may add to their suffering and worries about pain, tiredness, limited mobility, and lack of self-confidence are experienced to be a barrier to a sense of well-being in activity (Perry et al., 2012; Uhrenfeldt & Høybye, 2015)

Loss of functioning, and increased dependency common after HF (Peeters et al., 2016) are in the older population perceived barriers for being active (Franco et al., 2015). Fear of falling (FOF), prevalent in the lives of older people after HF and for 58% a barrier to be considered after six months (Jellesmark, Herling, Egerod, & Beyer, Dec 2012), is a serious condition that can lead to avoidance of activity (Deshpande et al., 2008) and affect the mobility (Scheffer, Schuurmans, van Dijk, van der Hooft, & de Rooij, 2008). Being confined to the home from a FOF or due to barriers in the physical environment can negatively affect activity and recovery (Bower, Wetherell, Petkus, Rawson, & Lenze, 2016; Moran et al., 2014).

Experiences of well-being seem to facilitate activity which for older people living in the community may be connected with being with peers, feeling safe, and receiving social support, while striving for well-being, better health, and independency (Baert, Gorus, Mets, Geerts, & Bautmans, 2011; Franco et al., 2015). The meaningfulness of being active seems to be vital when aiming for the improvement of well-being, functioning and participation in social life. A systematic review on self-efficacy and well-being after HF describes well-being to be connected with a sense of being in control, feeling part of a community, and being able to manage in everyday life. Whereas receiving help when dependent after HF is experienced to cause worry but also to increase a sense of being able (Rasmussen & Uhrenfeldt, 2016). For older people, a strong sense of identity and being respected as an individual in the relationship with helpers seems to decrease anxiety, helplessness, and feelings of being worthless (Bridges, Flatley, & Meyer, 2010; Gregory, Mackintosh, Kumar, & Grech, 2017; Holm & Severinsson, 2013).

Earlier qualitative studies describe older people´s experiences of participation in exercise and rehabilitation ((Resnick et al., 2005; Resnick et al., 2007; Tung, Cooke, & Moyle, 2013; Wykes, Pryor, & Jeeawody, 2009), their mobility levels (Taylor, Barelli, & Harding, 2010) and promotion of recovery (Griffiths et al., 2015; Robinson, 1999). However, taking an existential perspective, it is in activities in the familiarity of everyday life people find meaning in being active (Heidegger, 1962). This study is initiated by four communities and a non-university hospital calling for a physiotherapist (first author) to acquire local knowledge of older people´s experiences of being active after HF. The aim is to explore facilitators and barriers for being active experienced by older people during the first six months after HF surgery.

Methods

Design

Choosing a phenomenological-hermeneutic design (Heidegger, 1962), we use individual semi-structured repeated interviews, collecting data at two weeks and six months after discharge after HF surgery (Brinkman & Kvale, 2015). The study is the initial part of a longitudinal study interviewing the same participants four times exploring how the meaningfulness of being active may change over the course of 18 months. The design is influenced by Gadamer´s thoughts on the hermeneutic circle as a process of coming to understand through interpretation continuously moving between the parts and the whole of data expanding our previous understanding (H. Gadamer, Weinsheimer, & Marshall, 2004). Within this methodology, interpretation is taken to be unavoidable, imbedding prejudices in the process. This requires that we as researchers avoid letting biases reflect upon our own pre-understanding in a process of openness towards new possible meanings aiming for our individual horizon to be fused with the otherness of the participants´ experiences into a new understanding.

Participants

Participants were included (*n*=9) at the non-university hospital initiating the study. Due to a delay because of few admissions, participants from a similar size and admission-area non-university hospital were included (*n*=4). Criteria for inclusion were: aged older than 65 years with pre-HF limitation of functional ability, not living in a nursing home, no other actual fractures than HF and able to speak about experiences in Danish. Gatekeepers were physio- or occupational therapists providing participants with information sheets about the study and obtaining signed informed consent (World Medical Association., 2001). When possible, the first author contacted the participant prior to discharge to initiate a personal contact, offer further information, and settle on a time and place for the interview. Thirteen participants from seven different municipalities were included in the study. Due to one participant´s death and one participant being in a mentally difficult situation leading to drop out, 11 participants were interviewed at six months.

Data collection

The individual semi-structured interviews were recorded on an Apple® smartphone using the Apple app 'Memos'. At two weeks, interviews took place in the participants own homes (*n*=10), at a temporary residence in a rehabilitation-center (*n*=2), and a day-center (*n*=1). At six months, interviews took place in participants´ own homes (*n*=10) and in nursing short-term room (*n*=1). The first semi-structured interview-guide was developed based on the authors pre-understanding of older people´s situation after HF and further inspired from a theoretical framework of personal well-being (K. T. Galvin & Todres, 2011). The second interview-guide took an open life-world approach, allowing the participant to talk more vividly about everyday experiences that were important for them and how they experienced their activities. For example, rather than asking "What makes you feel like being active" during the first interview round, questions such as "When do you feel comfortable" were posed in the second interview round. At both interviews, questions were open-ended; probing and reflecting back aimed at letting a deeper meaning emerge, whereas silence allowed participants´ new thoughts to emerge. Some participants were of few words and closed questions were used while paying attention to non-verbal expressions such as body language and tone of voice. To establish a positive atmosphere, the interviewer listened actively by keeping eye contact and nodding to encourage the participant to keep talking (Brinkman & Kvale, 2015). Immediately after each interview, notes about impressions and situations were made.

Data analysis

The two interview rounds were collected for a mutual analysis. The analysis of the data from the first interview round expanded the researchers´ horizon and sensitized the search for similarities, contrasts and developments in the second interview round, leading to common themes. A predetermined, structured five-step movement was used to organize and analyze the data (Brinkman & Kvale, 2015), requiring the first author´s immersion in the data for a period of approximately 18 months and progressively focus on the emergence of themes. Interpretation was a circular movement between the five steps ensuring credibility when a new understanding of the parts e.g. of one interview was reflected in a better understanding of the whole i.e. all interviews and vice versa. Firstly, interviews and notes were listened to and re-read several times to get an overall sense of the participants´ historical accounts. Secondly, the first author selected meaning units relevant to the research question as expressed by the participants and condensed them into essential statements. Thirdly, a description produced from the underlying meaning of the condensed meaning units rephrased the participants' own choice of words leading to step four: interpretation in relation to the research question. A deeper understanding beyond what was actually said was achieved. Rather than coding, keywords pointing to an existential meaning were attached, pointing towards step five: development of themes and subthemes (Brinkman & Kvale, 2015). Establishing dependability and confirmability through peer validation, reflections with co-authors on preliminary themes was leading to revising and refining the interpretation (Fleming, Gaidys, & Robb, 2003). We chose citations to confirm themes representing older people´s experiences during the first six months after HF. The researchers contrasted the theoretical framework of well-being with the preliminary description of themes to reach a further understanding at an existential level.

Ethics

The study was registered in the Central Denmark Regional Research Council journal no. 1-16-02-422-15. Gatekeepers introducing the study and study-handout shielded participants from researcher´s eagerness to include them. Prior to each interview, the researcher ensured confidentiality, the option to withdraw from the study at any time, and the possibility to decline from answering any question during the interview. Debriefing after each interview was an opportunity to discover if participants had bad experiences, taking the time to talk in a more informal way and achieving a sense that the participants´ dignity was in place. The abovementioned steps were taken to avoid causing harm, an issue in old age calling for specific attention (Sarvimaki & Stenbock-Hult, 2016).

Table 1 Characteristics of participants

Code name Age/ gender	Interview context (1st / 2nd interview)	Walking aid prior to HF	Dependency in daily activities prior to HF	Illness mentioned by participants	Housing conditions/ family status
Dorthe 73/F	Own home / own home	Walker outdoor	Cleaning. Medicine dosage	Difficulties speaking from stroke ten years ago; diabetes; fracture of left upper arm	Old-age housing, town area / widow, children nearby
Hannah 77/F	Temporary rehab stay / own home	Walker outdoor	None	Almost blind with decreasing eye sight due to calcification of the retina; injured nerve in leg; osteoarthritis in the back	Villa, town area / widow, children nearby
Ingrid 77/F	Own home / dropout due to death	Walker	Cleaning	Heart attack; recently completed rehabilitation after spinal cord injury surgery resulting in paralysis of legs; use catheter	Villa, town area / married, unclear where children live
Bodil 78/F	Own home / own home	Walker	Shower. Cleaning. Medicine dosage	Recently completed rehabilitation after stroke with reduced function of right leg; anemia; dizziness; kidney problems	House, countryside / widow, living with son and daughter-in-law
Karen 80/F	Own home / own home	Walker	Shopping	Parkinsonism; reduced function of first and second finger after surgery of the shoulder; contra lateral HF five years ago; dizziness	Ground level flat, town area / widow, children nearby
Margrethe 80/F	Own home / own home	Walker outdoor	None	Chronic headache; dizziness; cancer surgery	Apartment, 6 steps up, town area / widow, children far away, male friend nearby

Anna 85/F	Own home / nursing short term room	Walker	Compression stockings	Gout of fingers and neck; pneumonia at time of HF	Old-age housing, town area / widow, children nearby
Joan 85/F	Own home / own home	Walker away from own plot	Security visits. Cleaning	HF	Villa, town area / widow, children nearby
Nelly 89/F	Own home / dropout due to mental state	Support from furniture or person	Medicine dosage. Cooking. Cleaning. Shopping	Almost blind with decreasing eyesight due to diabetes	Apartment, 6 steps up, town area / widow, children nearby
Lene 90/F	Own home / own home	Walker outdoor	Cleaning	Chronic obstructive lung disease	Old-age housing, town area / widow, children far away
Else 92/F	Temporary rehab stay / own home	Walker	Cleaning. Laundry. Medicine dosage	Almost blind with decreasing eyesight due to diabetes	Villa, town area / widow, children far away
Frank 70/M	Day-care center where he stays every weekday / own home	Wheel chair, walker, four point cane	Transfer. Personal hygiene. Dressing. Wife manages the house	Completed stroke rehabilitation nine months ago. Right sided drop foot. Not able to use right hand. Cancer successfully treated. Repeated surgical removal of fistulas in the brain	Villa town area / married, son living at home
Gunnar 77/M	Temporary rehab stay / own home	Walker, support from wife	Transfer. Wife manages the house	Reduced balance and memory from stroke; several herniated discs; spinal stenosis	Villa, town area / married, children nearby

Results

Table 1 provides an overview of participants. They had a mean age of 74½ years. Two men and one woman were married; ten women were widowed for at least five years. Participants living alone all had family, neighbors or a close friend helping with various practical tasks. After discharge, all participants needed more help than before the HF. At the time of the first interview, eight participants received help from homecare while three participants were temporarily staying in a rehabilitations center. At the second interview, 10 out of 11 participants had increased dependency on help or aids than before the HF.

Experiences during hospitalization seemed to be in the background and could be hard to remember; descriptions tended to be undetailed, except experiences of suffering that made an impression.

To explore facilitators and barriers for being active among older people the first six months discharged after HF surgery, we identified two main themes in the data analysis: "Inner dialogue" and "Struggling and striving".

Inner dialogue

Unable to manage independently after HF and resume their previous level of activity, participants felt homeless and unsafe in activity. To feel and come home to well-being and a sense of familiarity with their life-world, they had an ongoing inner dialogue between their "Inner driving forces" and "Inner limitations". They were moving between openness towards possibilities and lost hope of overcoming limitations.

Inner driving forces

A sense of belonging was a driving force related to sharing and being in this together with other people, having a feeling of being connected with and still belonging to the world. Reaching for a normalization of their everyday life at discharge participants were dependent on practical help from family and friends. Sharing, practical tasks and talking about problems, sharing newspaper and celebrations brought forward joy, contentment and the value of progress. Through long relationships, family members knew their preferences and routines and Lene explained how they took care of '*small things you normally do not count, but just do. But in my present situation they are big things*'. Particularly for participants recently discharged and isolated in the home, visits were energizing and for Joan, friends visiting made her feel that '*they haven´t forgotten you*'. During six months experiences of change and something new to life gave participants the energy to continue. Going to social events or a day-care center was a welcome break from the everyday boring routine and participants even felt they belonged to a community. Bodil was feeling lonely in her home but '*the two days I´m at the day-care center, they are doing it for me, it´s like an oasis to get there'.* To have a sense of belonging was a confirmation of being alive and gave feelings of hope and meaningfulness.

A sense of identity was a driving force related to being able to do things independently and feeling dignified. Participants were aiming for homecoming in a sense of being in touch with personal capacities and values. Being persistent, creative, positive, vigilant and thoughtful supported a sense of being, and experiences of progress maintained hope and self-confidence. Responsibility was a matter of finding solutions to problems and having duties. Karen had managed baking cookies for my second visit:

> *'... I tell myself, you HAVE to try, and then when a full baking sheet is ready, I go and sit down for a while. Then back to the oven again. It can take a long time, but I have nothing but time'*

Though at times participants pushed the limits of their capacities, they moved about with care to avoid falling while balancing a need for being active with a need for rest. Independency and not having to wait for help was even more important than avoiding pain, and participants had a drive towards deciding for themselves. Self-imposed activities of doing house-hold tasks, exercising, going for walks or participating in social activities brought a sense of dignity. For Joan, this led to unintentionally offending a bypassing woman, who offered to help picking up a pile of coiled leaves in the driveway:

> *'... she was quite offended. I´ve [...]told her that it wasn´t that I didn´t want her help, but it was because I needed to do it on my own [...]. You tell yourself "You can do it when you have to" and then you do it'*

In contrast, being at peace with the situation was a driving force. Participants accepted suffering and limitations as part of life and becoming old; they came to terms with prolonged rehabilitation and dependency on help or assistive devices; abstained from making unrealistic plans; and found meaning and joy from being in their own homes or from good memories. Living with chronic limitations from her Parkinsonism, Karen philosophized that '*when you are ill, all you want is to be well again, and when you are well what then; [...]then you don´t think about it as much'* indicating how suffering was balanced from appreciating the presence of good experiences.

Inner limitations

All participants had experiences of feeling helpless related to a sense of own identity under pressure. Being unable to do what they longed for was distressing and they were suffering defeats when they wanted to do more than they could handle. The will alone was not sufficient when the body was vulnerable, and they were despairing about a loss of their capacities. Margrethe recently stopped attending physical therapy training six months after the HF, but recognized then how her pain came back:

> *'...I wanted the pain to stop[...]because going to the city, that´s always nice. But I don´t feel like going at all anymore because I can´t walk, [...]and I don´t really enjoy a trip like that'*

Primarily at the first interview, participants felt helpless in experiences of undignified dependency, feeling inadequate not able to get out of bed, or to be a hostess for guests. Their efforts did not necessarily pay off and at six months, slow or lack of progress put their hopes under pressure. For Lene, her dream of being active and socializing without worries in old age had shattered:

> *ALL the things that I had thought I would be able to do nice and slow [...] just isn´t happening. Now, it has become exhausting instead just to get a spoon or [...]get something from a shelf.'*

Participants felt out of control and in doubt about what to expect. At the first interview, fears were about moving with pain and about how much the leg could withstand. Prior to discharge, the future was blurry and they worried about keeping up the steam after discharge and about permanent loss of their ability to walk. Feeling unprotected after discharge, participants had an inner dialogue about avoiding being in a precarious situation to avoid losing control. Staying at home from valued social activities was preferred when it was strenuous to get ready in time, risky to go home in the dark, or depending on other people which meant they could not decide the duration of a visit.

Participants had concerns about becoming a burden. Striving to be in equal relationships, they loathed the idea of laying a burden on family or friends. For Joan, this meant resigning from going to bingo, which used to be her great passion:

> *'you have to get a [...] seat, go get the cards and [...] you have to go to the bathroom once in a while. [...] Then, going a little downhill back to the car again is not so nice. [...]you don´t want to inconvenience everyone just because you broke a leg'*

However, inner driving forces and inner limitations were intertwined. Participants had a dialogue about how to keep on being active when their hopes were under pressure. For Lene, ordinary tasks had become strenuous because it took her so long to walk from one place to another; for example, bringing a cup of tea to the living room while balancing it on top of the walker; and if she forgot a tea spoon, it was the whole trip again. Rather than despairing, Lene used her creativity:

> *'I made kind of an emergency drawer; if I forget anything. Actually, it is a sewing table [...] on wheels. [....] I have a knife, teaspoons and [...]the essentials. You have to figure something out. You sit there thinking about what you can do about this and that'*

Also, Lene at six months was distressed about being unable to participate in social activities as before the HF. When I asked whether she could still have a good life she said:

> *'Yes, because then I´ll just make changes to some of the things I CAN do. For example, [...] these entertainments nights; I can´t dance and jump around, but I can BE there [...] see the joy of life other people have. And what they are able to do, even if I´m not able to the same, it´s kind of comforting'*

A feeling of helplessness and not being in control was balanced by homecoming in a sense of identity, a sense of belonging, acceptance of limitations and new meaning in joining social activities. When inner driving forces dominated possibilities for well-being in activity were developed; when inner limitations dominated, suffering and inactivity increased.

Struggling and striving

Suffering brought on by the HF changed participants´ relation with the surrounding world and themselves. Aiming for homecoming, they were struggling to be active while striving for progress described in two sub-themes "Building relationships" and "Considering conditions and complications". Cooperation with staff, public services and physical surroundings could facilitate or be a barrier for homecoming, whereas complications from health issues always were barriers.

Building relationships

Staff facilitated participants´ well-being in activity when the relationships were trusting and cooperative, which meant feeling acknowledged for their efforts while receiving information, feedback and encouragement. Participants acknowledged staff expertise and following their advice and recommendations they felt safe about their training and accepted complications to be normal. Training was meaningful when it was challenging, not too difficult and addressed and helped to overcome complications. Hanna appreciated how cooperation training with physiotherapists built confidence:

> *'I get compliments all the time – that feels nice because I do the right things. [...] I get the sense of how it feels to have a leg that doesn´t quite cooperate, how it´s supposed to feel so I can carry on training myself'*

In hospital and immediately following discharge, help was experienced to be a prerequisite for being active, mitigating the limiting repercussions from the hip HF. When having someone around, participants dared to do things on their own, like Bodil who, terribly afraid to fall, said that '*the reason why I continue to have home care is that I simply don´t dare to be here alone and take a shower.* Taking pride in managing independently, participants struggled to receive only the help necessary and gradually reduce help in daily life activities.

Contrasting, when there was no cooperation with staff but rather orders, suspicion or neglect, participants felt homeless and left on their own. Pain was inflicted when hospital staff were moving the leg brusquely or demanded swiftness in activities, and a fall was the consequence of staff neglecting other diseases than the HF. Anna was dependent on help in her home in the wait for re-surgery of the hip and felt overlooked when busy staff did not recognize her needs:

> *'...and then all of a sudden, they forget a lot of things for example when I used a walker, they could forget to put it where I could reach it and there are a lot of things like that. That´s no good'*

Participants felt stuck and helpless when the help they needed was not present.

Table 2 Frequency and type of complication

Type of complication	**Iw. 1**[1]	**Iw. 2**
Lack of physical capacity [2]	*n*=10	*n*=9
Pain	*n*=10	*n*=3
Side-effects from medicine	*n*=8	*n*=2
Other diseases or disorders	*n*=7	*n*=10
Fear of falling	*n*=8	*n*=7
The whole leg affected (not only the hip)	*n*=6	
Fatigue	*n*=4	*n*=3
Swelling of leg	*n*=3	*n*=2
Movement restrictions	*n*=3	
Permanent catheter with bag	*n*=1	
Disturbed sleep	*n*=1	*n*=1
Subluxation of the hip	*n*=1	

[1] Iw. = Interview

[1] Lack of strength in the leg, risk of falling, not able to walk, not able to climb stairs, reduced hip mobility, not able to stand on the leg, limping

Considering complications & conditions

Complications were body and health issues (table 2). They added to the sufferings of participants and deprived the joy of being active. At the first interview, though pain was unbearable and required slowness during mobility, it was accepted as natural. Participants loathed drug side-effects and struggled on their own to find a balance between pain and pain killers. Complications deprived participants of their energy and could turn into a vicious circle of growing bodily discomfort requiring inactivity adding to lost hope for regaining mobility and a social life. Though complications threatened the well-being of being able to move freely and participate in meaningful activities, apart from Gunnar whose wife continuously took action to secure ongoing supervised training, participants did not ask for additional rehabilitation.

Table 3 Conditions: available and missing public services

Facilitators: available public services	Barriers: missing public services
'The hospital (staff) saw to that I received a rehabilitation plan to start rehabilitation at home' (Joan)	*'(Before discharge) I wanted to go to a rehab centre so I would not be alone and there was someone to guide me when walking. Hospital staff say it is not possible in my community' (Anna)*
'I have to go to the doctor with my diabetes. I just call a flex-taxi. I can bring my walker. They are good at helping me' (Anna)	*'Rehabilitation doesn´t start until three weeks after discharge' (Frank)*
'I was about to go home, but as long as I depend on help with everything, a bed and toilet in the living room is necessary. However, this doesn´t work. So, we chose a rehab center' (Else)	*'It´s hard not to be able to do anything for a long time. I didn´t start rehabilitation until after a week. It could have started earlier' (Ingrid).*
'If I had gone home from hospital without previous modifications in the home, I would feel like being in a prison. In rehab, I hope we have time to find out what is wise to get done at home' (Hannah)	*'For a walk in the garden, what I miss the most is to have a second walker. I need to bring it all the way down the stairs and back on the carpet with dirt. They took it away from me' (Else)*
'Being picked up and dropped off and picked up again (to go to day-care center), that suits me amazingly because people I don´t know, it´s horrible! I´m not sure I would go if I had to do it on my own' (Bodil)	*'I wanted to walk to the supermarket and had to apply to borrow a walker. It took four weeks before I received it' (Hannah)*
'We do all kinds of activities at the day-care center; play cards, watch movies, sometimes bingo, sometimes go out walking together. When the weather is nice, we even go down to the harbor and look around' (Bodil)	*'Due to the hassle in maneuvering the walker over the doorstep, I mostly stayed in the bedroom. It wasn´t until two weeks after discharge I had ramps put over my doorsteps' (Karen)*
'The physiotherapist from rehab went home with me to see to that it was safe to send me home' (Ingrid)	*'The doorways are too narrow or the walker too broad. Moving the walker through the doorways, I hurt my fingers' (Lene)*
	'I can walk to the bus, but it´s too far to walk around between shops to buy a new pair of shoes for my compression stockings' (Lene)

Conditions were public services (table 3) and the physical surroundings. External settings and surroundings enabled a sense of feeling confident, provided possibilities and expanded reach and horizon such as; modifications of the home, assistive devices, day-care centers and public transportation. Contrasting, participants felt lost or powerless with inadequate assistive devices or incomplete modifications of the home; or when stuck in the home unable to get around using public transportation. Surroundings could give a sense of homelessness when purpose and possibility for being active seemed lost, such as being in a hospital environment with nothing to do. For Nelly, a nearly blind woman who had recently moved due to a fire in her previous apartment, being in her home was a painful experience of discouragement and imprisonment. When asked about what could make her want to move, she said:

> *'Well I run, walk around here; when I get tired of being in the bedroom I´ll go out here (to the living room); then I´ll go out into the kitchen [...]. If I can´t pass the time in one place, I´ll go somewhere else and then there is nothing to do but wait'*

Confined to her home there was no respite from the boredom of having nothing to do in a restricted space. To go out of the home, they needed the physical surroundings to be supportive. For Joan, stairs was an insurmountable barrier preventing her regular visits next door to a good friend confined to a wheelchair:

> *´'It´s been a long time since I´ve been inside because I haven´t had the courage to go around and walk up the stairs no, no. Before, I would have gone up through the kitchen to have a chat. Just to talk for half an hour which means a lot'*

Participants planned where and when they would go and preferred the safety of walking near other people, on smooth surfaces, in good weather and for short distances.

Discussion

This study investigating older people's lived experiences of facilitators and barriers for being active after HF, confirms evidence on the influence from symptoms, functioning, personal, social, and environmental factors (Baert et al., 2011; Franco et al., 2015), and adding an existential perspective points to the unified experience of facilitators and barriers. Contributing to the framework of well-being (Todres & Galvin, 2010) in showing examples from the life-world of older people with a HF, this study expands the understanding on the intertwined experience of well-being and suffering. The HF was a life changing event and experiences of well-being made it possible to find meaning in being active and were resources while balancing suffering. Suffering in this study appeared as feelings such as a sense of homelessness, hopelessness and not being in control in the absence of longed for activities, and participants were struggling and striving to have a sense of belonging, of identity and of being at peace. Participants were active, struggling within the boundaries of their physical or environmental limitations. Well-being was possible when a sense of being at home was present or when they striving for "homecoming" expanded possibilities of being active. Depending on whether their inner dialogue was dominated by their inner limitations or inner driving forces, well-being or suffering alternatingly were in the foreground of experiences, reinforced by the relationships they were building with staff. When participants felt recognized by staff for their effort and not only the results, their self-confidence increased; feeling recognized may be fundamental when benefitting from staff expertise (Rasmussen & Uhrenfeldt, 2016) and information received after HF (McMillan, Booth, Currie, & Howe, 2012). Contrasting, feeling treated as an object when orders and suspicions were part of older people´s relationships with staff could raise a concern about being able and lead to a downslide into suffering. This is possible when a range of small incidents pushes towards a feeling of being unable, and loosing courage may be the result (Uhrenfeldt & Høybye, 2015). While treating older people as experts on their own health, respecting their needs, problems and desires in life (Holm & Severinsson, 2013) may support them in being active and overcoming suffering.

The framework of well-being described a sense of identity as a feeling of being able, an unspoken feeling of optimism (K. T. Galvin & Todres, 2011); this study added the understanding that a sense of identity was not only a state older people were in, but a dynamic inner dialogue concerning possibilities and limitations for being active. It was a resource connected with a sense of self-confidence and the possibility for progress while keeping on making plans and carrying out tasks and duties. A sense of identity seems to be closely related to independency and possibilities for making one's own decisions (Holm & Severinsson, 2013) and even possible when being in a dependent situation (Rasmussen & Uhrenfeldt, 2016). However, feeling unable while being dependent after HF, a sense of identity was under pressure and participants had feelings of despair. Galvin & Todres (2012) point to how a sense of not being able is linked with feeling useless, and how withdrawal into isolation and inactivity may be the consequence. To fully understand whether the individual's experience of well-being in activity after HF is compromised, attention towards a potential split between what they want to be able to accomplish and feelings of helplessness (K. Galvin & Todres, 2012) is called for. Helplessness and despair may deprive a sense of energy (K. T. Galvin & Todres, 2011), whereas involvement and increased feelings of being in control in activities that are wanted may increase older people´s agency (Gregory et al., 2017).

Feeling safe and supported by the physical home, the outdoor environment (Moran et al., 2014) , and availability of public services, participants were active in a sense of comfort and well-being. After HF, the home, the streets, and the journey from home to other places may become places of in-hospitability, feeling homeless and insecure when moving (Todres & Galvin, 2010), and anything that can modify the inhospitable constraint in the environment and improve a sense of freedom to move without a risk of falling may facilitate well-being and activity. Further, being confined to the home in the early phase after discharge, participants of this study felt isolated with nothing to do; an experience of immense suffering and inactivity.

Evidently older people in this study did not recover from the HF and they were struggling to be active within the limitations from complications and conditions. Some of their health problems may be modifiable; FOF seems possible to reduce through prolonged rehabilitation (Dukyoo, Juhee, & Lee, 2009; Ziden, Frandin, & Kreuter, 2008) and progressive rehabilitation programs targeting deficits in balance, strength and mobility after HF are argued to give older people the best chance of avoiding impaired functioning (Sims-Gould, Stott-Eveneshen, Fleig, McAllister, & Ashe, 2017). However, participants did not seek assistance. Not seeking help may be connected with a sense of meaning in activity being maintained from being able to manage independently and deciding for themselves. Other studies point to a lack of knowledge about services (Gregory et al., 2017) or preserving a sense of dignity. There seems to be a risk of overlooking possibilities for further improving older people´s mobility and well-being in activity after HF.

Implication for practice

Approaching older people´s own needs and wishes emphasizing how homecoming to a sense of belonging, a sense of own identity, as well as acceptance is possible may increase their possibilities for being active. Additionally, we suggest that hospital staff members consider whether a feeling of belonging is possible after discharge; without meaningful relationships that are practical, vitalizing and a confirmation of being precarious to other people, a discharge directly to the participant's home may not be the best solution. Further, community guidelines and community staff may secure a called for continuous pro-active attention towards older people´s hidden needs for further interventions beyond the end of rehabilitation.

Methodological consideration

It could be a limitation of this study that only 13 participants are included and only 11 participants still remain in the study at the second interview. However; analyzing the large amount of data from 26 hours of interviews is time-demanding and adding more participants may have led to superficial analysis without capturing the depth of individual experiences (Brinkman & Kvale, 2015). Rather than demographic variation, depth is the aim within phenomenological-hermeneutic research (Norlyk & Harder, 2010). Still, participants represent variation in age, sex, dependency prior to and after the HF, family relationships and residential status, adding details and richness to the analysis.

The pre-understanding of the first author being a physiotherapist caring about improving functioning and independency after HF may have influenced the findings. However, congruent with the phenomenological-hermeneutic methodology through discussions, the interdisciplinary research team identified biases from prejudices and developed a deeper understanding (Fleming et al., 2003).

The study was undertaken within the tax-financed Danish healthcare system. Depending on recognizability of the individual situation and context (Shenton, 2004), results from the study may be transferable to older people suffering from recent loss of functioning due to other diseases e.g. after long-term, geriatric hospital stays. The two men in the study both had wives helping out and taking care of everyday tasks, while men living by themselves may have different experiences of being active.

In three cases, the presence of relatives at the interviews might have been a limitation but was ultimately experienced to be a strength. Regarding ethical concerns, they were not asked to leave as participants´ situations are considered part of a reciprocal relationship with close relatives (Haahr, Norlyk, & Hall, 2014); instead, the researcher underlined that the focus of the interview was the participants´ experiences. On two occasions, the presence of a son and a wife seemed to provide a sense of comfort for the participants. Further, the relatives´ presence was judged to present a foundation on which the individual experiences of the participants stood out more clearly (H. Gadamer, 2013). Participants who had previously suffered a stroke occasionally had difficulties elaborating on topics; specific attention towards their comfort during the interview involved repeatedly selecting questions about action considered less intrusive than questions about beliefs and values (Price, 2002). Further, the interviewer occasionally suggested directions for answering questions about meaning. This was a limitation and the researcher took special precautions during analysis to include only suggestions that seemed meaningful for participants: the non-verbal communication e.g. their tone of voice, and the knowledge about participants from repeated interviews was considered.

Conclusion

This study provides knowledge regarding the existential nature of older people´s experiences of facilitators and barriers for being active after HF increasing the understanding of how well-being may be possible, and suffering diminished during the first six months. Two themes describe how a sense of coming and being at "home" is a facilitator and possible when suffering is balanced in an inner dialogue between personal driving forces and limitations. After HF, older people are struggling and striving, and relationships with staff, conditions and complications influence on their well-being. Non-demanded help from health care professionals may be relevant to avoid older people sliding into feelings of helplessness and being unable after HF. Possibilities for well-being may be facilitated through enhanced inner driving forces, environment- and health-improvement also beyond six months after HF. Future research taking an existential approach to gain more detailed knowledge on how well-being is possible as a resource for older people after HF during hospitalization and during specified interventions in communities is needed.

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Paper 2

Aged adults' everyday life experiences of being active one year after hip fracture (In draft)

Birgit Rasmussen, Claus Vinther Nielsen & Lisbeth Uhrenfeldt

Abstract

Despite a high risk of continuous loss of mobility and well-being when living a sedentary life one year after hip fracture (HF), aged adults´ individual experiences of being active are not well understood. The aim of this article is to understand aged adults´ everyday life experiences of being active 1 year after HF taking an existential. Based on Heidegger´s and Gadamer´s thinking a phenomenological-hermeneutic study design focusing on people´s being-in-the-world is applied. The study reports results from interpreting individual interviews of 9 aged adults conducted 12 months after a HF. Being part of a larger qualitative interview-study with four interview-rounds, this study reports results from the 3rd interview conducted 12 months after a HF. A five-step process of meaning condensation used to secure participants own experiences, testing pre-understandings allowed for a new understanding to emerge. Three themes describe aged adults´ experiences of being active after HF as "Renewal", "Enduring" and "Loosing courage". Stretched between experiences of well-being and suffering vulnerability is a central part of their being-in-the-world calling for attention towards maintaining courage.

Keywords

Hip fracture, aged, physical activity, everyday-life, qualitative, rehabilitation, well-being, hermeneutics

Background

The long-lasting consequences of a hip fracture (HF) and experiences of being active go beyond functional ability and progress. This study is concerned with the human aspect of being active in everyday-life one year after HF, and how an experience of well-being may be a resource, when the aim is to increase possibilities for being active after a HF (Todres & Galvin, 2010). Being active can for aged adult prevent a negative spiral of loss resulting in isolation and further illness experiences (Bullington, 2006). However, one year after HF aged adults´ possibilities for being active may be challenged in different ways. Decline in mobility, ability to manage in daily life and feeling depressed are barriers to being active for aged adults (Baert, Gorus, Mets, Geerts, &

Bautmans, 2011) and found to be three times higher in aged adults people with a HF compared to aged adults without (Bentler et al., 2009). Aged adults are very inactive after HF (Zusman, Dawes, Edwards, & Ashe, 2018) which may increase the risk of chronic diseases such as diabetes, cardiovascular diseases and cancer (Lee et al., 2012), and decrease their well-being and physical and mental health (Vogel et al., 2009; World Health Organization, 2010).

To improve future possibilities for well-being and being active a special attention on aged adults people needs during recovery after HF is highlighted (Bentler et al., 2009). Despite rehabilitation programs focusing on progress of functional ability (Handoll, Sherrington, & Mak, 2011) loss of functioning after HF may be permanent (Magaziner et al., 2000) leaving aged adults to find a way to be active when living with fatigue, pain, decreased mobility, difficulties managing activities of daily life and increased need for help (Bentler et al., 2009; Bertram, Norman, Kemp, & Vos, 2011; Rasmussen & Uhrenfeldt, 2016). Some keep on struggling and exercising, aiming to return to their prior mobility possibilities (Gorman et al., 2013); while for aged adults feeling vulnerable (Bruun-Olesen 2018) and struggling with experiences of disappointment (Stott-Eveneshen et al., 2017) being active may be connected with a sense of hopelessness, without joy, and a reminder of lost identity (Ziden, Scherman, & Wenestam, Jan 2010). To regain a sense of own identity aged adults who feel vulnerable may need to balance between a sense of vitality while acknowledging loss (Nicholson, Meyer, Flatley, Holman, & Lowton, 2012). Social relationships are found to be health promoting and a meaningful context for being active in old age (Holt-Lunstad, Smith, & Layton, 2010) and still possible to improve one year after HF (Magaziner et al., 2000). After HF relationships are experienced to be supportive and essential for an experience of having recovered well and maintaining a sense of well-being (Young & Resnick, 2009; Ziden et al., Jan 2010). Still, after HF aged adults seem to spend more time in or even become confined to their homes (Bertram et al., 2011) and regretting lost possibilities for socializing may add to aged adults´ suffering after HF (Handoll et al., 2011; Rasmussen & Uhrenfeldt, 2016). However, knowledge on the individual experiences of the meaningfulness of being active within these conditions are missing.

Theoretical framework

In this study the starting point for understanding the human experience of being active one year after HF is the lifeworld, by Heidegger (1962) elaborated as being-in-the-world: the human pre-conscious, everyday connectedness with the world (Heidegger, 1962). Being-in means dwelling-in, feeling at home, and belonging to the world as a familiar place. To be human according to

Heidegger (1971) is to fulfil our own being dwelling within "the fourfold", a human existential condition described as: "the earth", symbolizing the natural world, i.e. the ageing body, and personal beliefs; "the sky", illustrating the unknown and changing times; "the divinities", a longing or hope beyond rationality; and "the mortals", representing human being-towards-death (Heidegger, 1971). Being and acting in human life in this study is considered at an existential level as part of a network of plans or purposes in the interwoven connectedness between time, space, body, other people, identity and mood (Heidegger, 1962). These existential conditions are described by Todres and Galvin to express 18 variations of well-being and suffering delineated as possibilities of dwelling and mobility or a combination of both. Dwelling is a willingness to be in the present situation, a sense of being at home and acceptance; whereas mobility is a sense of possibility and of moving forward on towards a new horizon (Todres & Galvin, 2010). One year after HF feelings of excitement and an experience of continued possibilities for recovery may be blended with an experience of acceptance and being satisfied with what activities it is possible to perform despite limitations. Bringing spatiality forward well-being is possible as a sense of excitement e.g. for aged adults being invited into exploring new places on excursions with a day-care-centre; or a sense of feeling comfortable and supported being confined to the home after HF. Well-being does not eradicate suffering but is a resource and a transcendental possibility available in human life through difficult times. Suffering can be an experience of homelessness which may initiate a striving for feeling at home in one´s situation. A HF can be a profound disturbance of the appearance of the fourfold as well-known way of being-in-the-world, why a new balancing of equilibrium between mobility and dwelling, and between limitations and possibilities may be called for. How being active for aged adults may provide possibilities for well-being one year after a HF is a subject not well understood.

Aim

The aim of this study is to understand aged adults´ everyday life experiences of being active one year after HF taking an existential perspective.

Methods

This study is designed as a phenomenological-hermeneutic interview study and influenced by Heidegger´s reflections on language as a medium of correspondence with experiences of people while researching their factual everyday-life (Heidegger, 1962) and Gadamer´s thoughts on understanding through the hermeneutical circle (H. Gadamer, 2004). The study is part of a longitudinal study aiming to capture experiences of being active at different time-points after HF. First study used interviews at two weeks and six months after HF to explore barriers and facilitators for being active (Rasmussen, Nielsen, & Uhrenfeldt). This second study explores experiences after one year at a time where improvement of functional ability most likely no longer is possible. The third study follows participants´ individual development, change, and continuity to explore experiences of meaningfulness when aged adults are active 18 months after HF (Rasmussen, Nielsen, & Uhrenfeldt).

Participants

The nine participants in this study were included approximately one year earlier during hospitalization after HF. Physiotherapists and occupational therapists informed about the study and received signed consent during their stay at the orthopaedic department. Inclusion criteria were people older than 65 years living in their own homes, able to enter a conversation about everyday experiences, and having mobility limitations prior to the HF. At the time of inclusion thirteen participants agreed to be part of the study. Since then three participants had died; one participant´s health had deteriorated and by a daughter judged too vulnerable to speak about her experiences. First author called the remaining nine participants on the phone approximately six months after the previous interview and was allowed to meet them in their homes again.

Data collection

Data were collected from May to July 2017 using individual, semi-structured interviews. To further a symmetrical dialogue and avoiding the interview to be stressful the researcher did not bring an interview guide; however to maintain focus and feel relaxed on beforehand had thought about topics to be addressed (Fog, 1998). Adding a conversational-like situation provided access to the speaking of words, the body, the pauses, the atmosphere, things in the surroundings calling the interviewers attention to how the fourfold was gathered(Heidegger, 1971). Noticing how they moved about and where and how they sat; things they showed; and places they spoke about in their close vicinity added to a deeper understanding of possibilities for comfort and activity. Opening the conversation could be participants starting to speak about their experiences in the hallway; or speaking around the coffee table. For participants less talkative the researcher could start the agenda speaking about last visit. Questions were very open, for example asking about the good experiences since last time we met. Following up could be silence, repeating words, probing, interpreting or asking for specifications (Brinkman & Kvale, 2015). The recorded interviews were transcribed verbatim. Immediately after completing the interviews notes were taken of observations and first impressions of participant´ whole situation.

Analysis

The interpretation was hermeneutic and a circular process of transforming participants´ expressions of meaning and significance into a new and deeper understanding (H. Gadamer, 2004). Using a word document to organize data this study applied an analytical five step process of meaning condensation (Brinkman & Kvale, 2015). The interpretation not only was stepwise. A horizontal and vertical movement through data on each step of analysis secured an on-going circular movement between the parts and the whole of each interview and of all interviews, thereby staying faithful towards participants´ being-in-the-world. This supported a progression of thoughts and an on-going dialogue with the data (Heidegger, 1977). When in doubt about how participants´ experiences had changed during the first year after HF, former interviews and the researcher´s interview notes were re-read (H. Gadamer, 2004). Firstly, all interviews were transcribed verbatim, listened to, and read several times. Secondly, natural meaning units from each interview were condensed into briefer statements. Encounters were presented so they appeared sound and coherent when contradictions, errors, or inconsistencies appeared (Debesay, Nåden, & Slettebø, 2008). Thirdly, staying close to participants´ choice of words condensed meaning units were rewritten into a more abstract description of the underlying meaning. On the fourth and fifth step the existential underpinning of the study was kept in mind. The fourth step interpreted data in relation to the research question. We secured close relation to data by mixing participants own words with more abstract terms (Smythe, Ironside, Sims, Swenson, & Spence, 2008). On the fifth step the deeper understanding of what at and existential level was significant to the participant was written into non-redundant themes and sub-themes (Brinkman & Kvale, 2015). Selected excerpts from participants illustrated the connection between themes and lived experiences.

Ethics

The study was registered in the Central Denmark Research Council journal nr 1-16-02-422-15. Obtaining informed consent underscoring that withdrawal was possible at any time the study met the Declaration of Helsinki principles (World Medical Association., 2001). Participants received no payment for being interviewed. Discernment rather than rules was used to meet ethical demands and caring for participants (Brinkman & Kvale, 2015). The interviewer was aware that being familiar with participants from two former interviews, there was a risk that feeling intimately related they may reveal more than they intended, what Fog (1998) named "The Trojan horse"(Fog, 1998), why specific focus was on informing about possibilities for not answering, or for requesting asking the recording to be stopped.

Findings

The nine participants (see table 1) had a mean age of 81½ years ranging from 71 to 93. Apart from Frank, who had recently moved into an apartment in nursing home facilities, all still were living in their own homes. For all participants family were central part of their life and well-being experiences. Six of participants had close contacts with neighbours and all participants talked about a spouse, children, friends or neighbours helping with daily life chores. Apart from Margrethe, Joan and Else participants several times a week joined activities together with other aged adults outside the house, four were assigned to a social day-care-centre. Dorthe´s walking had improved compared to prior to the HF due to less pain after replacement of her osteoporotic hip; the other participants had more difficulties walking. Except for Joan and Bodil participants had experienced other health problems since the HF.

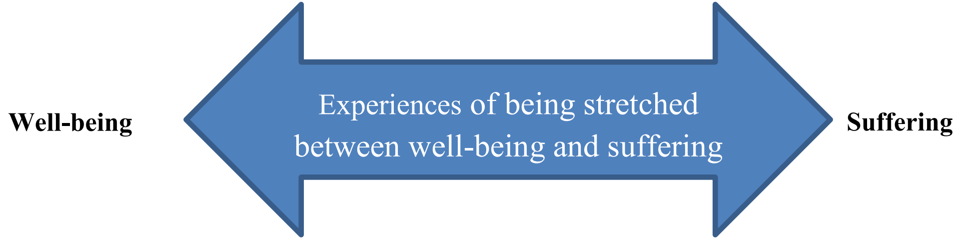
Table 1 Characteristics of participants

Code name Age/ gender	Walking aid	Residence	Marital status and examples of relationships
Dorthe 75/F	Walker outdoor	Older friendly housing. Town area.	Widow. Children nearby and far away; at least weekly contact; celebrates birthdays and Christmas; help out shopping for big items. Almost daily contact with neighbours Two weekly days at social day-care-centre
Bodil 79/F	Walker	House. Countryside.	Widow. Living with son and daughter-in-law Two weekly days at social day-care-centre
Karen 81/F	Walker	Ground level flat.	Widow. Children nearby; shopping together once a week; weekly visit from daughter helping out with small jobs Daily contact with friend next door Participates in activities at nursing home
Margrethe 80/F	Walker outdoor	Apartment, 6 steps up. Town area	Widow. Children far away; visits, celebrates birthdays and Christmas; Close, male friend visiting three times a week and daily contact on phone
Joan 86/F	Walker outdoor away from the house	Villa. Town area.	Widow. Children nearby; help out gardening; contact several times a week; Befriends other relatives Telephone contact with neighbour several times a week Visits from red-cross friend
Lene 91/F	Walker	Older friendly housing.	Widow. Children far away. Participates in numerous activities for elderly, Bingo, talks with neighbours and knows a lot of people.
Else 93/F	Walker	Villa. Town area / widow,	Widow. Children far away; visits, celebrates birthdays and Christmas. Twice a year visits overnight from family and have regular contact on phone Neighbours are good friends; do the shopping and collect medicine
Frank 71/M	Wheel-chair	Nursing home for three months. Still married, wife lives in their house	Married. Lives apart from wife; overnight visits at home every week-end. Spend all weekdays in social day-care-centre
Gunnar 78/M	Walker	Villa. Town area / married, children nearby	Married. Almost always together with wife; children nearby visiting regularly Good friends living in another city visiting 3-4 times a year Two weekly days at social day-care-centre

The main dimensions of experiences of being active are described in three main-themes: Renewal, Endurance, and Loss of courage (figure 1). One year after HF aged adults′ lives were full of contrasts. Living with being under change was a transition into increasingly reduced functioning and increased vulnerability. They were stretched between experiences of well-being feeling renewed and experiences of suffering loosing courage; between these two extremes they were active while enduring being exposed to losses and taking up the challenges of life to experience well-being.

Figure 1 Themes related to Theory of well-being

Main themes	**Renewal**	**Endurance**	**Loss of courage**
Mobility	Feeling meaningfully alive	Taking up the challenge when well-being is at threat	Facing loss and loosing courage
Dwelling	Feeling nurtured	Settling with limitations and maintaining courage	



Renewal

This theme describes through two sub-themes experiences of "feeling meaningfully alive" and "feeling nurtured and safe" how participants longing towards being with other people were maintaining hope and the strength to continue being active.

Feeling meaningfully alive

Participants kept on reaching out for other people. Being with other people and feeling part of a community focus turned away from limitations, loss, and feeling the nearness of death; and towards a new beginning and feeling alive. Sharing experiences in common activities e.g. at music events or at day-care-centre; and being together at special events such as birthday-parties brought feelings of flow and being alive. This was apparent from specific meaning units in the analysis of data and from the way participants addressed and spoke about other people throughout the interviews, the photos they showed, phone-calls during the interviews etc.; at times participants would lack words, but when speaking about being active with family and friends they relaxed while talking lengthily.

Other people caring and reaching out to understand their situation gave a sense of well-being feeling alive in the present. This could be experienced in very diverse situations of being active reaching from a bus driver helping with the walker and bags; to neighbours being a natural part of managing everyday affairs for example shopping or decorating for Christmas. Being in a day-care-centre healthcare-providers besides providing possibilities for meaningful activities also helped framing community into lived life between people, avoiding aversion and isolation.

For Lene getting to know people and greeting people in the street confirmed her sense of being alive and made her feel that "*... I´m still considered a human being not just a sad case, [...] I´m not just someone running around not knowing where I´m going, but I actually know what I´m doing*." Small considerate actions such as choosing to bring a stick along instead of a walker hoping it to be easier for the person helping when going down stairs or in and out car; or serving home baked cookies for helpers and people coming by participants maintained a sense of well-being. Joan´s neighbour had been admiring her white Peonies and afterwards she reflected that he would like a bouquet for his wheelchair-bound wife, a friend through many years: "*So I picked a bouquet and went over and said, 'You can bring this for (female friends name) to enjoy'. She's not going anywhere nowadays. Now I can see through her window it's on the table in the living room*". Participants were not only receiving but feeling dignified persistently trying to do things independently. When in need for help to get down groceries from shelves without reach at the supermarket Lene explained: "*I have a particular technique; I keep on trying to reach the stuff I want, and when someone is passing, I look straight at them, and keep on looking till they ask if they may help me*". Avoided asking for help dignity was preserved.

Feeling nurtured

In moments of being absorbed in perceptual pleasure and complete emersion in activities the heavy weight of everyday challenges vanished. Feeling nurtured for example being in the sun and sensing the fresh air; enjoying a favourite cup of tea by the terrace door; and playing chess or reading books participants restored the strength to endure and keep on reaching for possibilities to unfold their own being. Also, a sense of renewal, that something new could happen and there was something to look forward to nurtured participants´ hope and longings for being active, e.g. going out to meet and talk with other people, going shopping or just looking at shops. Being able to make own decisions and going about their daily life gave a sense of freedom and renewal. However, being dependent on homecare-appointments and waiting for helpers could prevent this, which by Lene was overcome by a secret deal using a home-made signal system by the doorway.

Participants took action to feel nurtured. For Lene the effort of cutting down some plants on her terrace was a struggle but worth the effort. It made it possible to enjoy the sun sitting only in her morning gown for breakfast sheltered behind the plants but the plants low enough to keep an eye on what was happening in the surroundings. Asking Joan how she was managing, she spoke about how she had been struggling and now again was able to manage independently. Bringing my awareness to how this contrasted to meeting her a year ago she with a smile looked around her living room, clean, flowers in a vase, table set for coffee and said: "*well, just as you can see"*. Her home was a space for dwelling and feeling nurtured from again being independent and in control: "*I have it the way I want it; no one bosses me around"*.

Exercising or going for walks participants were caring for the body, saving it from only being ageing and decay and as a contrast feeling renewed and adding to a healthy life-style. For Karen what she valued about physiotherapy was *"You won't shrivel up into nothing. Or turn into a vegetable"*. Improved mobility of the hip now made it possible to better take care of herself and a bunion on her little toe by adding a bandage which until recently had not been possible. Some participants hoping for progress were training on their own or continuously seeking out professional support. Participants felt nurtured from the interpersonal skills as well as the knowledge of healthcare-providers, feeling more confident in future mobility possibilities. For Lene a physiotherapist who *"...knows what she is doing"* provided new understanding of the interrelatedness of the body and nurtured a hope to feel more comfortable and safer during mobility. Gunnar couldn´t walk alone, but trusting both the physical strength and the vigilance of an employee at the day-care centre who took the time to go for a long outdoor walk, he felt confident to push the limits of his capacity: *"I feel safe; he can take me, if I´m falling he´ll catch me in time"*.

Endurance

This theme describes in two sub-themes experiences of facing challenging problems in everyday-life while enduring a life of gradually more restricted possibilities. Loss of well-being was imminent and feeling the nearness of death due to progressing health problems they were struggling to maintain courage and reaching for possibilities to unfold their own being in life.

Taking up the challenge when well-being is at threat

Well-being was at threat when freedom and possibilities for being active gradually or suddenly were reduced e.g. from a new fall, other diseases or when chronic diseases got worse. Aiming to stay in their homes and avoiding loss participants were taking on life challenges. Being active required extra resources and being active on the verge of what was possible to endure it was a challenge to maintain hope, enjoy life, and pursue life projects. Though well-being was at threat feeling exposed to loss and exhausted, they were doing their utmost to be active and exploring ways to endure. Jane spoke about how hard she was struggling to keep her house and garden, and how her children were scolding her; asked whether she couldn´t stop working so hard she replied: "*No I can´t [...]. I can and want to do it myself [...]. That´s how it´s always been"*. Enduring to be active restored a sense of dignity, a feeling of being alive, sound, and normal.

In an interplay between own actions, environment and receiving help from other people participants were struggling to feel safe. Taking up the challenge they walked slowly, used walking devices, and walked together with someone else, walked even in bad weather; managed gardening despite a fear of falling for example leaning unto a weeding tool; and used their creativity to manage everyday tasks. Lene explained that: *"So if you can´t take care of yourself, you have to do it anyway. There´s no yelling* '*can you help me with this, can you help me with that*'. *It has never been like that"*. It was worthwhile working hard to be true to own values and taking up the challenge was part of their identity.

Settling with limitations and maintaining courage

Limitations from feeling vulnerable seemed to be an on-going lesson learned. The body was calling for attention, and participants avoided taking chances and being in unnecessarily risky situations. Maintaining courage was possible when feeling safe and protected in a manageable and coherent everyday-life. For Lily, almost blind and walking unsteadily everyday-life mostly took place in her kitchen "*because I´m used to being here and it´s ok. That´s the way it is"*. Strictly following daily routines and carefully organizing their actions e.g. when taking a shower, which was perceived to be a delicate situation, participants felt less exposed to the danger of falling. Participants endured settling with limitations while reaching for a balance where efforts where consistent with available resources. Easy access to things saved sparse resources and was a way to preserve energy to do other tasks or to socialize. Lene had created a system where clothes were left out in the open, because then she could *"find it without having to overexert myself by having to search high and low through drawers and cupboards to find this and that".* When it was too hard female participants endured giving up on handling everyday chores independently, accepting help from family and friends. However, for some being dependent on help was a burden to be endured and they were afraid of being a burden. Settling with lost possibilities for doing what they longed for, other activities less physically demanding could be a replacement. Frank used to spend his best hours outside in the garden, hunting, or fishing; though longing for his past life possibilities, now confined to a wheelchair with nothing else to do he took up reading to be his passion.

Telling stories about their life and laughing about own inadequacy participants with a sense of own identity were settling with limitations. It was a kind of dwelling, a process of maintaining courage; however, it also was a protection. Avoiding feeling undignified participants preferred receiving help from people who knew them in the light of their past and their life story, which most often were family members. Dependency on help from strangers could mean withdrawal from social activities. For Joan Bingo was a passion given up after the HF because she was dependent on help; her way back was a voluntary visitor who turned out to be a friend who knew about Joan´s earlier position as Chairman of the Pensioner´s Association. Karen now in need of help to take her walker into the bus, rather stayed home than went to Bingo: *"it´s not nice needing help for practically everything [...] getting out of the car I need an arm to hold on to [...] I get upset [...] when, I have always been able to. [...] I´d rather have my own people with me (kids) [...] someone I know. They´re easier to talk to, I think, than strangers"*. Participants felt vulnerable and exposed to the judgement of other people and staying away courage was maintained.

Loos of courage

This theme describes participants´ experiences of facing loss and loosing courage when being active was an uneven struggle and hoped for progress did not appear. Feeling exhausted and unable to do what they wanted disappointment overshadowed future possibilities, hope and courage was lost, and apathy was foregrounded. Bodil had "*black days where nothing mattered!"* She felt *"it is boring being me"*, and she was "*lacking energy".* The body no longer self-evidently was sustaining mobility and activity. Joan was walking without her walker and suddenly afraid of falling would think: "*well how do you place those feet [...] and will that make you lose your balance"*. Mobility was risky and feeling failure and disappointed unable to do what they wanted they were losing courage. For Lene facing an eternal chain of exhausting days; trying to accomplish everyday tasks which earlier she accomplished without giving it a second thought, and - forced to give up - her sense of self was disturbed. The HF was a rupture of her life and of her dreams: "*I feel that I´ve aged too quickly; [...] all of a sudden now you can´t drive anymore, boom! [...] you don´t have the strength to go and rake in your garden; boom! You can´t make your own food; [...] little by little, you can´t do it anymore.* Everyday challenges were too big; it was an odd match to manage and using more energy than they received from being active participants were losing courage. It was not easy to ask for help and being with family and friends they avoided becoming a burden, e.g. by staying at home or conforming to what was easiest for the people helping out.

For two participants dependent on help loss of courage even was reinforced by healthcare-providers actions or thoughtlessness or when dialogue was missing. Else was left feeling imprisoned when they took away her second walker which prevented her from going out into the garden, and she didn´t know how to replace it. For Lene when helpers did not recognize her needs and wishes, help at times increased her suffering and deprived her of, rather than maintained her well-being. She had been assigned extra help to re-organize her clothes; however, the helpers did not fold the clothes the way she wanted; next time she took a pair of jeans out of the cupboard all the jeans came out, and now they were in a pile on the floor. She tried correcting the helper explaining "'*this is how I fold a shirt*'. '*Yeah well, that´s good I guess*' *she said, but she kept doing it her own way".* Her experience was that helpers *"take offence if you say something such as 'I would like it so and so*'." as if she was "*suggesting they couldn´t do anything right".* Therefore, Lene preferred to either do things on her own risking exhaustion or giving up and leaving it. Without respectful cooperation from healthcare providers participants were feeling more vulnerable sliding towards experiences of losing courage.

Further interpretation in relation to the fourfold

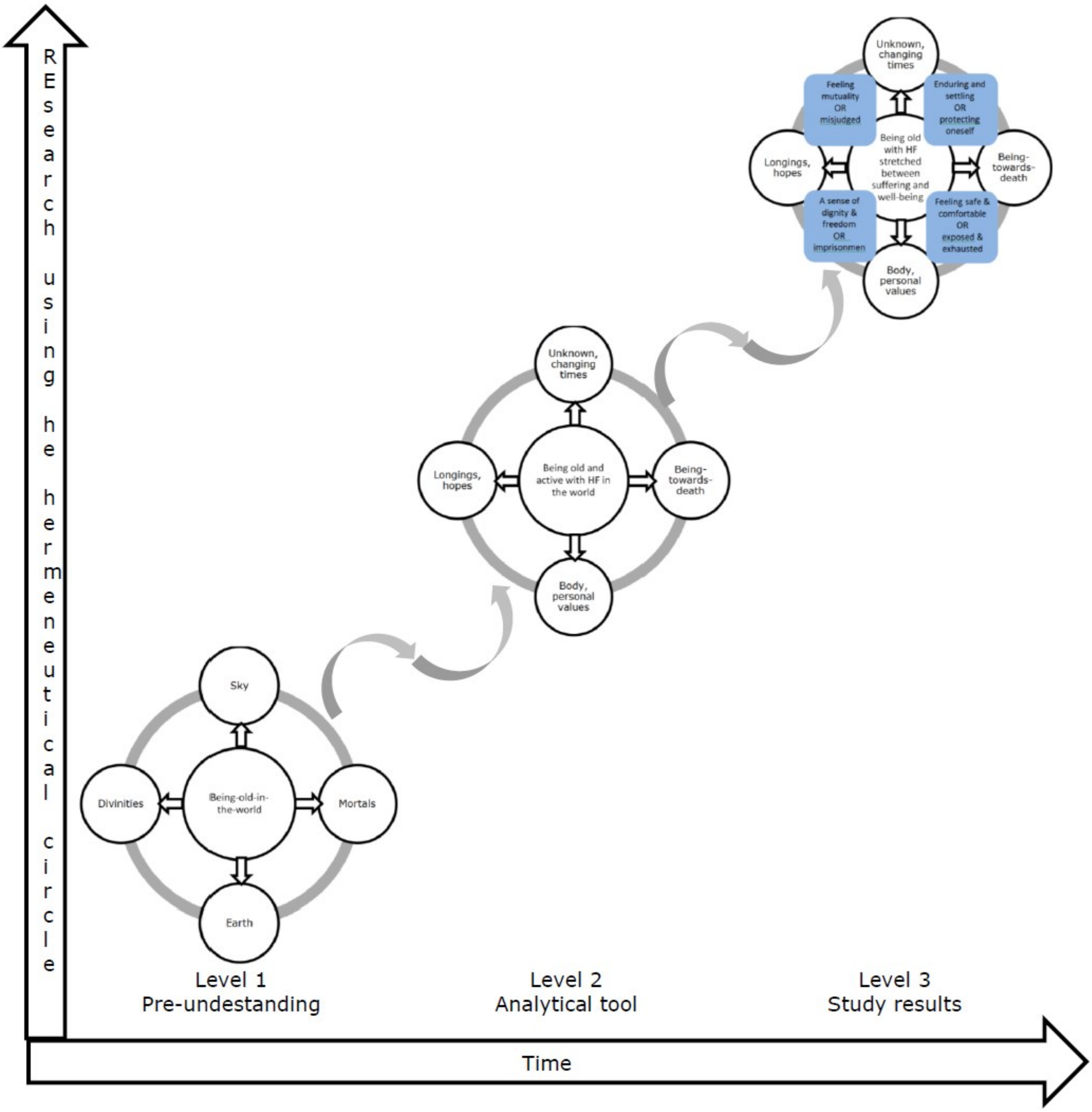
Aged adults in this study spoke about living towards death and had a sense of being stretched between experiences of well-being and suffering. Well-being dominated when mobility and dwelling was possible and there was an experience of renewal. Suffering was an experience of losing courage. Without dwelling they were struggling too hard and without mobility they limited their own possibilities for being active (Figure 1).

Interpreting the ideas about the four-fold in relation to the study in general and in relation to the parts and the wholes of main-themes and sub-themes a new whole emerged (Figure 2) Participants were moving between experiences of losing courage and feeling renewed and each of the four angles within the four-fold contains experiences of both (figure 2), e.g. feeling misjudged OR feeling mutuality. Though the order is arbitrary loosing courage is interpreted in an anti-clockwise movement and feeling renewed in a clockwise movement. Being within the fourfold and feeling vulnerable as a natural part of being human with a finite life after HF the unfolding of their being and experiences of well-being in activities depended on maintaining a delicate equilibrium. When suffering dominated, they were not able to dwell and feel at home in their lives which prevented the well-being of being active in any way (Heidegger, 1971).

Loosing courage was an experience of living with loss, a body slow and painful, and being pulled towards dependency and feeling exposed and exhausted; which may be interpreted as missing the nourishing from being supported from the body and personal values; the energy from the body withdrawn, prevented flourishing into being active and doing things independently. Slowness and apathy prevailed, and the finality of life seemed to be close. Disappointed and unable to endure or settle with loss in unknown and changing times they protected themselves and avoided being in unknown situations. They felt at risk of being misjudged by other people who did not know them and who may only recognize their weakness, not their strengths, and they were afraid of being a burden. Hopes and longings were lost, the world was closing down, and a sense of imprisonment was lurking. Loosing courage was reinforced when personal values were not respected by healthcare-providers.

Feeling renewed was an experience of being on the edge of giving up and again experiencing longings and hopes when mutuality in relations to other people was present. Reaching out for other people they were also reaching out for meaning of life itself. Something more to life than managing daily life affairs and doing things independently was present, which may be interpreted as something hidden, calling upon them to express their own being and humanity. They endured taking op life challenges in changing times and were hoping for further progress or were settling with new limitations and finding possibilities for being active even when the world became smaller. Turning their back on death, they in contrast took action or received help to feel safe and in moments of bodily comfort and of being totally absorbed in the moment they were nurturing their body bearing their own being to fruiting, feeling energized and at home. Appreciating moments of feeling free, able to decide and doing things independently, they felt connected with their personal value and a sense of dignity and a longing for life persisted.

Figure 2 Heidegger´s four-fold developed into understanding experiences of losing courage and feeling renewed



Discussion

The aim of this study was to understand individual experiences of being active one year after HF. Heidegger´s (1971) description of the fourfold and Todres´ and Galvin´s theory of well-being, provided a frame to understand at a deeper level the specific context aged adults were in one year after a HF; and how well-being and suffering was part of their existence (Heidegger, 1971; Todres & Galvin, 2010). Aged adults in this study spoke about living towards death and had a sense of being stretched between experiences of well-being and suffering (Todres & Galvin, 2010). Being in a phase of uncertainty and loss with progressing physical health-problems in the proximity of death in a study on experiences of frailty was described as a continual liminal state (Nicholson et al., 2012). This study provided evidence that a state of continuously being in between states of increasing vulnerability was experienced as both capacity and loss also was experienced by a group of aged adults talking about being active in everyday life after HF. In addition, the existential perspective of the study gave valuable insights about what may increase a sense of losing courage, and what may increase as sense of feeling renewed, being in this liminal state.

Nicholson (2012) used the term frail; we prefer the word vulnerability to underline experiences of being exposed, rather than experiences of being weak and breakable (Nicholson et al., 2012). Vulnerability for aged adults being active after HF in this study was an experience of the frail body, living with losses, and life becoming more limited; a need to protect oneself to maintain a sense of dignity; the struggle to feel an individual, competent being while acknowledging dependency in relation with other people; and the need to feel protected and safe when moving about in their life. The findings are in line with findings from a study on the meaning of vulnerability (Sarvimaki & Stenbock-Hult, 2016). However, findings from this study added insight that being aware of own vulnerability brought suffering, but also developed the capacity to endure and settle with suffering. Vulnerability was a transitional part of their being calling for courage, described as either a negative circle of losing courage and being inactive or a positive circle of feeling renewed and being active.

Findings of this study evidenced aged adults´ experiences of the body betraying them and not to be trusted as before the fracture, why activities became limited and being active they had to be careful, accept help and plan their activities in detail (Ziden et al., Jan 2010). New knowledge from this study was the elaboration on the actions and activities aged adults after HF were able to manage while carefully thinking about how to move safely and avoiding falling; they were creative, used routines and searched for easy accessibility to spare the exhausted body. As described by Birkeland (2009) they were settling with their new life situation, which didn´t mean giving up, in this study further elaborated to be an experience of taking up the challenge, with a sense of obligations towards life and towards one's own being (Birkeland & Natvig, 2009). Hope for progress for some participants and some participants still was present, which also was reported by Gorman (2013) in a study of the perception of exercise one year after HF (Gorman et al., 2013). However, the process of coming to understand own possibilities while managing own vulnerability in this study was more prevalent. This partly may be due to the focus of the study being existential experiences of being active in everyday life; and partly due to participants with more pre-fracture limitations of their physical functioning.

Among the participants of this study other people were essential for experiences of well-being. This finding supports and expands findings from other studies pointing to the centrality of help and support from other people, and how other people were encouraging, and helped remain optimistic after HF (Young & Resnick, 2009; Ziden et al., Jan 2010). Though aged adults being dependent in the background had a fear of becoming a burden, the courage to be active and keep on going after HF seemed to be deeply rooted in a feeling of being connected with other people. Such inter-subjective experiences described to provide both a feeling of desire being attracted towards other people as well as a sense of belonging (Galvin & Todres, 2011), may be searched for and stimulated by health-care providers aiming to support an experience of being active connected with feelings of well-being. However, this study pointed to, that feelings of hopelessness could be reinforced by healthcare providers not recognizing aged adults´ needs. Health-care providers applying specialist knowledge and community guidelines, but not entering a dialogue recognizing what matters to the individual may lead to aged adults loosing possibilities for well-being and for being active (Dahlberg, Todres, & Galvin, 2009). The risk of sliding into hopelessness is also a risk of depression (Bruggemann, Nixon, & Cavenett, 2007) and decreased possibilities for further recovery (Fredman, Hawkes, Black, Bertrand, & Magaziner, 2006). Contrasting, when physiotherapists in this study supported both physical strength and participants´ confidence in mobility and knowledge about the body, meaningfulness in being active was renewed.

Strengths and limitations

A strength of the study was the familiarity with participants from two previous interviews, adding knowledge and awareness to the constant process of testing pre-understandings of their being (H. Gadamer, 2013). Within hermeneutics interpretation is a process of developing a new understanding and one absolute truth does not exist. The trustworthiness of the interpretation arrived at in this study was the difficulties in arriving at a deeper understanding. The horizon of the first author was continuously enlarged from several meetings with the authors; comparing and contrasting findings from different participants; and from reading literature on illness experiences.

A limitation of the study was technical recording problems occurring two times. One interview was not recorded. It was ethically judged to be an unnecessary pressure on participant to repeat the interview for recoding purposes. To avoid forgetting essential statements the researcher (BR) immediately wrote a condensed transcript based on field observations and the interview, feeling quite confident to have captured the situation of this participant. At one interview the recorder after a short break, started to record on top of what was already recorded. To secure coherence in the participants story the interviewer (BR) immediately took notes and continued the interview. The participant had uncontrollable episodes of crying and was of few words and referring back to and repeating some of the topics previously addressed were an opportunity to elaborate on some topics.

Conclusion

This study contributes to knowledge regarding aged adults´ experiences of being active one year after HF by describing existential dimensions of their everyday-life. To have a sense of well-being they seem to consider possibilities to be active while enduring being vulnerable is a central part of their being. To improve aged adults´ well-being in activity one year after HF attention towards possibilities for maintaining a delicate balance between feeling renewed and loosing courage seems vital. We suggest that intervention studies, guidelines for practice and health care providers consider supporting aged adults´ sense of dignity and freedom; their possibilities for physical comfort and for feeling safe; and their possibilities for being in mutual relationships. Further, acknowledging the endurance aged adults possess, attention is suggested towards whether they are enduring too much or settling with too little; whether the limitations they are enduring are modifiable; whether they are able to settle with losses and limitations not modifiable; and whether they are at risk of losing courage.

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Paper 3

Being active 1½ years after hip fracture; aged adults` experiences of meaningfulness, a qualitative interview study (In draft)

Birgit Rasmussen, Claus Vinther Nielsen & Lisbeth Uhrenfeldt

Abstract

Background: Being active is vital and a source of well-being. However, 18 months after hip fracture (HF), progress seems to have come to a halt. Aged adults may feel vulnerable experiencing ongoing mobility limitations, dependency and limited possibilities for socializing. How aged adults experience the meaningfulness of being active during these circumstances is unknown.

Objectives: The aim of this study was to explore experiences of the meaningfulness of being active for aged adults 18 months after HF.

Design: A phenomenological-hermeneutic methodology based on the philosophies of Heidegger and Gadamer was applied to explore lived experiences of aged adults 18 months after HF. The study was part of a longitudinal study and three former interviews at two weeks, six months and one year helped build trusting relationships with participants and inspired and focused the semi-structured interview-guide. An existential theory of well-being and suffering considering health to be a balancing of mobility and dwelling was applied to more deeply understand the meaningfulness of being active.

Participants were nine aged adults 65 years or older with pre-fracture limitations of their mobility included while still in hospital after HF surgery

Method: Semi-structured interviews secured openness and were conducted in participants' own homes. The interpretation was a process of moving between the parts and the whole of the data as means of gaining a deeper understanding; and continuously testing pre-understandings. The analysis followed five steps: a) getting a sense of the whole b) delineating and condensing meaning units, c) interpreting meaning units, d) relating to study purpose and, e) developing themes and sub-themes.

Results: Two main-themes emerged. The main-theme "Feeling the continuity of life" had four sub-themes: "Feeling gratitude for present possibilities", "Feeling connected with earlier life-experience", "Thoughtfully managing vulnerability" and "A feeling of belonging and a spark of life with other people". The main-theme "Feeling vulnerable" had two sub-themes experiences of "Feeling thwarted" and "Feeling sad and regretting lost continuity in life".

Conclusions: The findings built on the participants´ lifeworld underline the call for a person-oriented stance emphasizing reflections on experiences of meaningfulness when helping aged adults to be active after HF.

Keywords

Hip fracture, aged, physical activity, qualitative, rehabilitation, well-being, hermeneutics

Background

Applying a human perspective (1), this study is concerned with aged adults´ individual experiences of the meaningfulness of being active 18 months after hip fracture (HF). Based on an existential world-view, meaningfulness can be an experience of being active as part of everyday-life (2), coming to understand how well-being is possible within challenging life situations (1). The challenge of experiencing meaningfulness after HF is the lost capability to manage everyday life tasks (3) and diminished possibilities for socializing (4). For 40-60% of aged adults, the challenge is never to regain prior mobility; for around 30 %, increased dependency in self-care; and for more than 50%, lost ability to independently go to places out of walking distance (5) These challenges are especially prevalent for aged adults with pre-fracture limitations of their mobility (6). For aged adults in general, a sense of meaningfulness seems to be active as natural part of everyday life integrating valued activities - e.g. being in familiar places (7), socializing, or being in the nature (8).

Feeling challenged by permanent loss of functioning and feeling vulnerable after HF, it may be a struggle to be active and on the edge of what is possible to endure (9). With persistent pain, tiredness, or fear of falling, aged adults can lose self-confidence (10), and feel imprisoned with a restricted social life and inactivity (11). Striving to find meaning and be active after HF, relationships with other people are described to be essential to avoid losing courage, and well-being may be connected with being able to settle with limited possibilities for being active (9).

When aged adults are inactive after HF (12) this adds to the risk of diminished well-being and can lead to further dependency, loss of functioning and premature death (13-15). After ending rehabilitation, a call for additional rehabilitation, including closer training and knowledge on how to improve own functioning was documented (16). Growing evidence shows that prolonged rehabilitation in the municipalities including modification of the home, exercises, education and social support can increase possibilities for being active and for well-being after HF. However, consensus and guidelines for municipality-based rehabilitation do not exist (17-20).

The authors´ pre-understanding

The ontological pre-understanding is Heidegger´s philosophy that the meaningfulness of being active in-the-world is evolving into a unified experience of past experiences carried into the present, while being concerned about the unknown future (2). Facing bereavement and loss, the meaning of being active changes and the awareness of life conditions including the finitude of life becomes present (2). As human beings we are open towards possibilities in life and feeling responsible for our own being-in-the-world, we can develop and take independent decisions to improve our lives when our being is challenged by the vicissitudes of life conditions, and when personal longings and beliefs are confronted (21). Based on Heidegger's ontology, Todres & Galvin (2011) described meaningfulness to be an intertwined experience of suffering and well-being (1). Well-being at its deepest core is an experience of dwelling & mobility in everyday life situations. Dwelling is to allow things to be the way they are in the present; and mobility is a drive towards new possibilities and a better future (1). Temporality, spatiality, embodiment, inter-subjectivity, identity and mood are interwoven nuances of life-world experiences; present at the same time, some are in the foreground, while others are the background giving coherence in life (22).

The epistemological pre-understanding is evidence on aged adults´ experiences after HF clarifying how positive experiences of feeling able to pursue wanted activities may coexist with negative aspects of living with limitations of physical ability and restrictions in everyday life (11). Midst experiences of illness, vulnerability, and disability, reconciliation with the fact that life after HF is not the same as before can be an essential resource and restore a sense of meaningfulness (10).

The professional pre-understanding is the first author´s (BR) three decade physiotherapeutic practice-experience working with in-hospital rehabilitation of aged adults; the significance of person-oriented care (23); and the fast-track in-hospital programme after HF, followed by a written rehabilitation plan effectuated in municipalities after discharge {{837 Kronborg,L. 2015}}. Municipality-based interventions in Scandinavia include a re-ablement perspective (24) and preventive home-visit on regular basis in the homes of aged adults are implemented (25), and access to e.g. rehabilitation, homecare, assistive devices and day-care centers is partly or completely cost-free for the individual.

Considerations of possibilities for being active after HF are based primarily on a wish to increase functioning and independency. However, for aged adults, existential experiences of belonging, feeling at peace or maintaining courage seem to be essential to experience that being active is meaningful. Knowledge on long-term experiences of being active after HF are important to address when communicating with aged adults struggling to recover from a HF. To the best of our knowledge, aged adults´ experiences 18 months after HF has not been studied and sstudies on the existential perspective of the meaning of being active after HF are missing. This study will develop ontological knowledge to be used in healthcare thereby adding to epistemological-based patient-oriented practice (23).

Aim

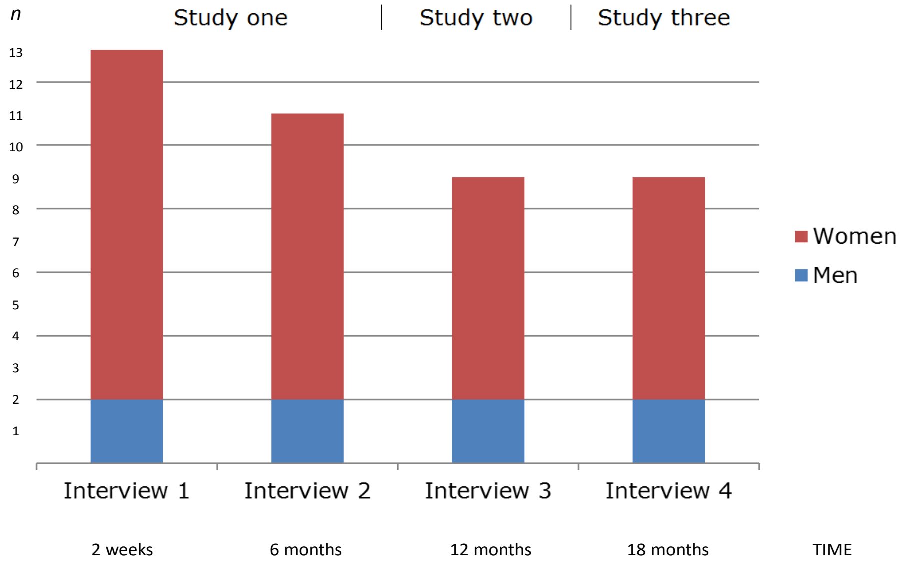
The aim of this study was to explore aged adults' everyday life experiences of the meaningfulness of being active 18 months after a HF.

Methods

The study is phenomenological-hermeneutic, a research tradition emphasizing the meaning people attach to their experiences and actions (2). Based on existential philosophy, interpretation is an inevitable part of the research process. Meaning appears within the researchers´ horizons when a new understanding arises from a fusion between what is already known about the phenomena and what is added from the lived experiences revealed by interacting with the participants(26). To gain a deeper understanding beyond the clinical perception of being active, a thorough challenge of one's own pre-understandings is applied using the hermeneutic rule of moving cyclically between parts and wholes throughout the research process, gradually reaching a deeper understanding including the horizon of the participants (27).

This study reporting findings from individual interviews 18 months after their HF is the third and final part of a longitudinal qualitative study concerned with the development over time of the same group of aged adults through four interview rounds (figure 1). The first study (28) used data collected at two weeks and six months after HF to explore barriers and facilitators for being active. The second study explored experiences of being active after one year, a time where improvement of functional ability most likely no longer is possible. This study follows participants´ individual development, change and continuity during 18 months. The repeated encounter with participants through serial, individual interviews allowed for more personal relationships and gave the researcher a profound understanding of their whole situation adding depth to the analysis (29).

Figure 1 Participants through four interview rounds



Participants

Nine male and female survivors of initially 13 participants recruited while still in hospital due to a HF agreed to meet with the first author a fourth time. Inclusion criteria were still? aged ≥ 65 years with pre-fracture dependency on help and / or dependent on walking-device prior (9).

Data collection

Data were collected between January 2nd and March 8th, 2018 meeting with participants in their own homes. Topics from former interviews needing more elaboration to be fully understood helped to inform the interview guide. The semi-structured interview guide based on open-ended questions had questions focusing on looking back and questions on experiences of being active i.e. situations that were difficult or situations with other people. The opening question "How are you doing" invited participants to talk about what was important in their life right now and was accompanied by double follow-up questions: questions used to create an atmosphere of being together on the subject; and questions to access knowledge(26). Follow-up questions, silence, repeating words, and nodding were used to direct the attention towards a deeper meaning of experiences (30). Questions referring to concepts (e.g. "Please tell me about your biggest limitation for being active") left some participants silent without an answer, whereas re-phrasing the question into an invitation to tell about an experience (e.g. "Please tell me about a situation where it was difficult to be active") they began telling a story from their every-day life .

Ethical considerations

The study was registered in the Central Denmark Regional Research Council journal no. 1-16-02-422-15. Informed consent was obtained prior to the first interview, and possibilities for withdrawal were re-negotiated prior to this fourth interview. Questions regarding confidentiality and the option of refusing to answer questions were repeated, and after the interview, debriefing was applied (31).

Analysis

The analysis was interpretive; staying close to the phenomenon as revealed by participants a hermeneutical circular movement between the parts and the whole was applied, which involved looking back on themes and selected transcripts from former interview rounds, aiming to grasp changes and permanencies in these aged adults´ experiences during 18 months after HF. To further a critical stance towards the pre-understandings of the researchers` the interpretative process was prolonged and guided by curiosity and openness towards what the data revealed about experiences of being active, reading and re-reading transcripts and literature (26). Transcribed interviews were analyzed following five steps of meaning condensation as described by Kvale (30). 1) All interviews were listened to and transcripts were re-read to get a sense of the whole account of each participant. 2) Meaning units expressing a connected whole were selected and condensed into more essential statements. 3) Condensed meaning units were rewritten to obtain a more abstracted understanding. 4) Considering the research question, the rewritten meaning units were challenged and reconstructed. 5) Meaning units were interpreted and written into themes and sub-themes expressing diverse experiences. Interpretations questioned in discussions and reflections with co-authors leading to new insights supported credibility and dependability.

Results

Participants were aged between 72 and 94 years, and all except one had decrease of functioning due to the HF. Three participants had died, and one withdrew due to poor mental state (Figure 1). This fourth interview, taking place in participants’ own homes, except when visiting Margrethe who had recently moved into a nursing home due to a stroke, lasted between 32 and 75 minutes. The first author felt welcomed as a familiar person e.g. being invited for lunch with a daughter visiting, allowed to enter though they had forgot about the visit, and the house was messy. Some wanted to fill the gap, up-dating the researcher on what had happened since the last interview, some asked about the interviewer´s personal life, and some showed things related to what they were talking about, e.g. pictures, presents or books.

Looking back on how they were before, the HF for some participants did not make much sense. It could be difficult to distinguish what had happened when. Rather than answering directly at questions about looking back at 18 months, some participants drifted into stories about how their life was now, about their family, or they were telling stories from before the fracture. They preferred talking about; their current situation, experiences of being with other people, and experiences of managing in everyday life.

Two main themes (Table 1) describe participants´ experiences of being active in the context of everyday life. The main-theme "Feeling the continuity of life" in four subthemes elaborates mainly on well-being experiences of meaningfulness, which are the experiences mostly in the foreground when aged adults were talking of their life. However, experiences were intertwined with experiences of meaninglessness described in the main-theme "Feeling vulnerable". These experiences were mainly present in the background.

Table 1 Two main-themes and six sub-themes

Main-themes	**Sub-themes**
Feeling the continuity of life	Feeling gratitude for present possibilities Feeling connected with earlier life-experience Thoughtfully managing vulnerability A feeling of belonging with other people
Feeling vulnerable	Feeling thwarted Feeling sad and regretting lost continuity in life

Feeling the continuity of life

Embodying vulnerability, participants were concerned about their possibilities for being active. Feeling the continuity of life was a sense of gratitude for present possibilities for being active, feeling supported by their own thoughtfulness and earlier life-experiences, and a sense of moving forward while feeling connected to other people.

Feeling gratitude for present possibilities

Feeling gratitude for present possibilities paradoxically added to a sense of moving forward and being connected to the temporal continuity of life. Living with uncertainty and the awareness that future possibilities for being active may be limited, and vulnerability might increase, worrying about the future did no good. When talking about the future and the risk of further decrease of functioning Else said that "*... I'm not going to spend time wondering about that. [...] that's no use*". Taking one day at a time, feeling gratitude for and appreciating the things they were still able to do was essential to feel part of the continuity of life. These experiences ranged from Frank appreciating the freedom possible after moving to a nursing home: "*I'll tell you, going to the bathroom by myself, that is wonderful. And brushing my teeth. But the bathroom, that's important, it's so nice because I don't have to call for someone*"; to Lene exclaiming: *"Well, I´m happy every time I can solve a task*". For Dorthe after having been close to dying gratefulness was talked about as a feeling always present in the background. Else, who was almost blind and could not go out on her own seemed sincerely content, never talking about any imprisonment, or regretting her situation. For her, not being able to manage independently, a good life implicated gratitude towards "*... that I have good helpers coming here*". Being able to stay in their own homes or do things was no matter of course but was appreciated as a gift of prolonged possibility for feeling independent and free. Joan was talking about going shopping in the supermarket and when asked what was so good about it she replied: "*then I know 'you can do it yourself'*". In the act of doing, participants confirmed that it was still possible to do it and by focusing on what they could do, they maintained a silent hope for being able, also in the future.

Feeling connected with earlier life-experiences

Feeling connected with earlier life experiences was related to a sense of meaningfulness in places allowing a sense of feeling at home with oneself. This was revealed in words, but also when showing a special book, things and photos in the home to the interviewer. Since childhood, Lene had been going to the beach. Now despite using a walker, she still enjoyed walking on the beach, sensing the agility from being used to maneuver on uneven ground: "*I uhm, feel myself being able to do a little of what I was able to before. I just have to think about how to do it. I didn't have to do that before, I'd just go, just walk*". For Gunnar, an excursion with the day-care-center to his former workplace which now was turned into an Exploratorium was: *"...one of the biggest experiences I've ever had (cries)*".

Feeling connected with personal capacities developed through life, participants had a sense of dignity. In everyday situations difficult to manage using and developing creativity, perseverance and patience participants were able to endure and keep on going. In waiting time for her son to come by and help her Karen was telling about the hassles trying to move a table and a carpet so she could wash the floor before he showed up. With a little laugh she said: "*I got it done*!" Keeping on making an effort for most participants was part of a sense of dignity living up to life-long values, as also expressed by Paul who had learned from his brother: "*You don´t give up*". Some participants also came to accept dependency as natural and part of becoming old. They aligned with limitations and with the fact that keeping on trying was too exhausting and some things were impossible to accomplish. This was the case for Joan who at a previous interview was exhausting herself to manage her own garden: "*when you have to do it, you can*" (interview 3). Now she had hired a gardener. Talking about herself with a smile she explained *"'she has gotten too old*". When asked how she felt about that she was without regrets: *"Well, I am going to be 87 next time after all*". Feeling connected with earlier life experiences and acknowledging one's own stamina through life, it was possible to build on one's self-esteem and self-confidence.

Thoughtfully managing vulnerability

Thoughtfully managing vulnerability was an experience of well-being maintaining a sense of identity and courage. It was a call from conscience do things, to care about one's own being and stay independent. Relieving the strain in everyday life and increasing a sense of safety and self-confidence was essential, and participants´ many experiences of how this was supported are presented in Table 2. Paying attention to the present, the body and the surroundings, participants had learned how to move with care to avoid falling, pain and using unnecessarily amounts of energy. During the interview, Joan went to her bedroom and brought back a device for putting on socks, stating that *"it´s helped me a lot"*. Being vulnerable, some risks were not worth taking and thoughtfully participants e.g. avoided walking on stairs when they were on their own. Each moment could call for thoughtfulness. It was a balance between being active and being careful, as stated by Else: *"I also have to be careful not to push it […] You have to use the strength you have for different things. So you take your walker and so on"*. It was a new way of moving and in earlier interviews, Lene and Karen expressed that it had been difficult but now since the previous interview they had avoided falling. Discovering possibilities for being active in a safe way could involve civil disobedience; not sure whether she was allowed to use the walker (a property of the government) when she went swimming in the ocean, Lene concluded: *"It helps me swim just as much as it helps me walk!"* Participants felt responsible to stay healthy. Lene also did exercises in bed every morning, for it was easier when the body was still warm and afterwards, she was*: "... able to happily jump around throughout the day"*. For some participants, managing vulnerability implied maintained hope of progress and of again being able to resume or more easily manage everyday life. For Bodil, hope of progress encouraged her zest for life: "If I didn't have that (hope), I might as well…sit here and wait for it to end". For Birthe, Gunnar, Karen, and Lene thoughtfully managing vulnerability, they were getting help e.g. receiving massage, or attending physiotherapy for effective training and knowledge about the body; thereby making it easier to move and increasing the self-confidence in the ability to manage.

Table 2 Experiences of strain relief and increased self-confidence

Relieving the strain in everyday life	**Increasing a sense of safety and self-confidence**
Modifying the home environment with help from municipality staff	Being in familiar places
Using assistive devices	Receiving help
Using routines and procedures	Being near other people
Having easy access to things	Exercising in the home or in groups
Going for walks or going swimming	Training with physiotherapist • Effective and demanding training in a safe environment • Knowledge about moving safely
Receiving massage	Avoiding walking on stairs, in the dark and on icy surfaces

A feeling of belonging with other people

A feeling of belonging with other people was something to look forward to. Sharing experiences and talking with other people provided a sense of something more in life than managing everyday chores. When Karen in the middle of struggling to move a rug beneath her sofa had an unexpected visit from her grandchild and his girlfriend, she declined their offer to help preferring to be updated on their life and whereabouts: "*'You are absolutely not helping me', I said, 'you are going to have your coffee'*". Participants were drawn towards being with other people in mutual relationships. It could require a lot of energy to socialize, but it was worth the effort of getting ready, getting out of the house, in and out of a car. Being active was more fun when they had a sense of belonging. For Bodil, walking alone just for the sake of walking, "*it does absolutely nothing for me*", whereas being together with other people it was easier. The attention was on being with other people and their common experiences. The interaction, what was happening was in the foreground, paying less attention to the act of being active. For Lene, meeting new people was essential: *"And I walk a lot. And what brings me the most joy these days is (talking to other people) […] I'm so chatty, you know, and I say hello to the people I meet and if they start talking to me, I will talk to them"*. Contrasting, other participants preferred being with people they knew, with whom they had a sense of belonging. Frank lived in a nursing home spending his week-days in the adjacent daycare-center; he enjoyed talking with people, helping out serving coffee but didn´t join in on the activities: *"... They go on outings, but that´s ok, I enjoy going with my son just as much; we talk about all sorts of things*". People who knew them from a long life provided a sense of safety and were a natural refuge from chaos, helping on practicalities as well as sharing life experiences of successes and failures. Family and friends literally yielded possibilities in life; going on excursions seeing new places, inviting for birthdays, helping to organize and carry out a birthday party for friends. Though participants were grateful to receive help, they also were leaning into the relationship as a natural thing, part of the lifelong mutual commitment of family or close friendships. As expressed by Anna, whose daughter helped with shopping "*well, that's how it's supposed to be*".

Being together with healthcare providers, a feeling of belonging was an experience of feeling respected, a sense of community and feeling safe and taken care of. When the help or advice they received related to problems they were experiencing in their everyday life, they felt acknowledged as dignified human beings.

Feeling vulnerable

Feeling vulnerable were mainly experiences in the background of experiences elaborated in the previous main-theme ("Feeling the continuity of life"), as experiences of *avoiding* feeling pulled towards greater vulnerability. In this main-theme, feeling vulnerable elaborated on more explicit experiences. Two subthemes "feeling thwarted" and "lost continuity in life" detailed how managing in everyday life was an ongoing struggle with uncertainty and unpredictability, and participants seemed to endure these experiences on their own.

Feeling thwarted

Feeling thwarted was an experience of being exhausted and embodying weakness, pain, and instability. A sense of unpredictability could prevent participants from doing what they wanted and struggled to do. Most of the women were feeling thwarted when trying to do things in the house but being unable to complete it or forced to postpone what they were doing. For Lene, to enjoy sitting on her terrace in her dressing gown drinking a cup of tea, she had to tend to some plants to be able to look at things happening in her surroundings: *"I do all I can, I have been removing withered plants but then it comes to a halt; I can pull them up and gather them but I can´t carry them away ... it annoys me"*. She would feel exhausted and when sitting down for a cup of tea, she would fall asleep; even after a rest, she wouldn´t have the stamina to carry on.

Feeling thwarted when receiving help limited by healthcare providers´ lack of human perspective or knowledge was a experience of loss of dignity / meaninglessness e.g. when meeting with specialists, focusing only on symptoms, not interested in how they were doing; or when homecare ignored their limitations and needs. Else had one helper who continuously told her to do the dishwashing after lunch; however almost blind she felt helpless, unable to see whether the tableware was clean. Lene felt thwarted by helpers, for example leaving a mess; or not respecting the way she was trying to organize things to make it easier to manage. Lene had succeeded in maneuvering boxes of diapers into the bathroom, stacking it so it looked nice and she could reach it from the toilet. Next morning a helper tore open one of the boxes so diapers were flowing out, and another helper *"...had been so clever as to put them [...] on the shelf behind my toilet [...] which means I have to go all the way behind and then up and reach for one of the diapers. You know what, I can't do that!"*. She had given up on telling them how she wanted things because she knew *"from experience how insulted they can get and then you'll get a snappy response"*. Feeling thwarted was also an experience of lacking knowledge about assistive devices. For Anna, this meant lying in the floor a whole night after a fall not sure whether helpers would hear her emergency call during night time; and Lene though longing to go to a market in a neighboring village only used her electric scooter for short trips because she didn´t know the capacity of the battery.

Feeling sad and regretting lost continuity in life

When possibilities for being active were reduced, participants were feeling sad regretting lost continuity with who they used to be. A part of who they were, was what they were able to do and accomplish, and when they couldn´t do it, they felt that an identity as independent, active and persevering was lost. The two men talked about lost possibilities for outdoor activities; the women mostly about household chores; men *and* women talked about limited freedom and limited possibilities for socializing. Persistently trying to do things but at times forced to give it up, Lene was full of regrets: *"Then I think to myself 'well, you are an old weakling when you can't even do that'"*. Bodil continuously regretted her lost possibilities for helping out in the house and feeling impatient to see results from her training she said: *"I think I should be getting more mobile faster" ..."It can´t be right that I won't be able to do some things, even though I´ve gotten old"*. Life had changed and it was difficult to accept. Contrasting, seeing no alternative Else, Frank and Karen had resigned and come to accept changed life conditions and things not longer possible to do. However, they talked about their loss with sadness, e.g. when Frank was telling that: *"There are many things, I want to do [...] I arranged roses, made flies for the fishermen [...] I was out catching trout and herring and plaice; there was something going on every minute, but that's over now"*. Karen choked up when stating that *"I'm used to being able to do everything; that's probably what's difficult to accept "*. She reluctantly accepted a need for increased help from her family: *"I'm going to have to accept that when I'm not able to do some things myself "*. Though almost blind and not able to manage her house or go out, Else never complained; *"that´s how it is"* and *"that´s how it goes"* was a common reply from her, for example when talking about friends being disabled not able to visit, or friends who had passed away. However, her occasionally quiet voice or how she looked down at her hands was interpreted as sadness. For one participant, a sense of continuity in life had stopped. Margrethe had lost a daughter to cancer, had suffered a stroke and now wheelchair-bound had moved into a nursing-home. *"I have nothing more to tell"* was one of her last remarks. Being together with other residents with whom she felt no kinship did not bring any joy, and unable to get into a car, she missed going on her usual trips with a friend.

Discussion

This study explored the meaningfulness of being active from the perspective of aged adults with pre-fracture dependency 18 months after HF. Findings in this study confirmed that they were embodying vulnerability and possibilities for managing everyday life tasks and participating in social activities were reduced (3). Within these conditions, challenging the meaningfulness of being active well-being was a vital resource.

Focusing on daily life experiences, this study adds to practices inspired by the concept of reablement (24). Healthcare providers aiming to close the gap between recommended and actual activity levels in aged adults 18 months after HF may be focusing primarily on progress of functional ability and independency. This can be meaningful for some and in this study for the participants for whom meaningfulness was connected with well-being as a temporal experience of hopeful orientation towards progressing future possibilities for better physical functioning. Without this hope, a felt invitation or motivation towards being active was missing. The findings are in line with earlier studies describing that a hope for progress increased motivation to be active and exercise (32), and when hope and belief in the future was missing being active was meaningless (11). In our study feeling hope was a resource helping participants to keep on struggling and trying. However, contrasting to Gorman´s study continuing focusing on progress and keeping on struggling for some was an experience of suffering, a finding that seems to be in alignment with what Galvin & Todres (2011) described as an experience of an "elusive present", a feeling of being unable to appreciate the present possibilities for being active. This also seemed to apply for aged adults 18 months after HF.

This study, being part of a longitudinal study, expanded on the understanding of how reappraisal of meaningfulness was an experience of developing possibilities for well-being through time. During the first six months after HF, hoping for progress was essential, and when progress was slow or absent it could bring suffering (28). Around one year after HF, hope for progress was still an issue. However, exploring how it was possible to be active in the proximity of death the future could be anxiety provoking, or not possible to grasp. Participants were moving towards settlement and reconciliation with loss and limitation. In the present study hope for progress was still essential for participants 18 months after HF in order to experience meaningfulness. However, for most participants, hope changed towards well-being experiences of being at peace, a sense of gratitude and appreciation of present possibilities. Being thoughtful and managing vulnerability was part of the process. The significance of being thoughtful in an earlier study on fear of falling has featured as carefulness, a protective strategy making it possible to be active and maintain an identity as independent, rather than a person at risk of falling. Aged adults adapted and found a balance between feeling safe and remaining active (33). Our study further elaborated on how aged adults of this study in trying over and over again were involved in a process of understanding. In the act of doing things, aged adults during 18 months after HF were discovering possibilities for being active, while finding resources in experiences of dwelling. It was a process of being thoughtful, caring about one's own safety, resources and health, and thereby aligning with their changing life situation. This didn´t mean that suffering was eradicated, but it was endured and coming to accept and "being at one with what is there" (1 p. 4) was possible over time. Being active with a sense of gratitude towards present possibilities, the aged adults of this study maintained a sense of meaningfulness. This way, the experience of life coming to an end did not prevent them from making sense of being active. This finding added to the concept "temporal dwelling" in the theoretical framework of well-being (22). A felt gratitude allowed for an ongoing appropriation of possibilities for being active. Opposed to the suffering experience of a blocked future, gratitude was a way of feeling connected with their own being, feeling "brought home" to the very simple event of "just being"' (22 p. 5). Contrasting, when aged adults of this study over time were unable to align with limitations and loss it could result in suffering from being without "dwelling" (34). In this study evidenced as an experience of hopelessness related to a blocked future; feelings sad and regretting loss; feeling unable; and feeling exhausted incapable of physically handling daily tasks.

Searching for and supporting possibilities for the well-being of inter-subjective experiences that are valued for the individual and "an invitation into a welcoming future" (22 p. 4), healthcare providers may convey to aged adults the energy to be active. For all participants in our study, hope and future possibilities mainly was related with inter-subjective experiences: looking forward to experiences together with other people. Similar findings were reported in a systematic review on aged adults´ experiences of being active (35) and in studies on aged adults´ experiences of a HF after one year (9,11,16). Social interaction can be a meaningful way for aged adults to challenge the limits of their ability (33), and aged adults may benefit from having fun and to be in a trust-based atmosphere (28).Our study added that to be active, it seems important for aged adults to have something to look forward to. Even small changes mediated through relationships with other people can contribute to this well-being experience. The importance of feeling kinship as well as the vitalizing experience of looking forward to experiences with other people has been a recurring theme during the four interview rounds interviewing the same participants during 18 months after HF. In all phases after HF, other people were essential both for aged adults´ possibilities for being active, as practical support and help, and as a source of feeling connected with a meaningful future, enduring the awareness of being mortal.

Person-oriented care is needed for aged adults to feel supported when the meaningfulness of being active is challenged in different ways (23). Aged adults of this study seemed to endure the ongoing uncertainty and unpredictability when being active in everyday-life situations on their own. Further, the aged adults who were dependent on help from healthcare providers had experiences of feeling thwarted when staff did not recognize the problems they were struggling to solve, or who they were as people. On the other hand, receiving help to make sense of being active, feeling safe and respected supported a sense of meaningfulness. Epistemological reflections together with an ontological perspective by Uhrenfeldt et al (2018) were argued to be fundamental when building a strong relationship, where people in need trust and follow healthcare providers´ advice (23). Results from this study pointing to well-being as a resource are indicative for healthcare-providers, and may help build consensus when developing guidelines for municipality-based rehabilitation e.g. planning activities in a day-care center, or developing preventive home-visits (36). Healthcare providers mainly focusing on using guidelines, being effective, and regarding the aged adults as consumer, risk adding to the suffering of aged adults (37), whereas emphasizing well-being can touch upon a motivation grounded in aged adults´ heart that may be more evocative than rational knowledge (38) and may be a relief making it easier to be active in the presence of suffering.

Strength and limitations

This study aimed to explore aged adults´ experiences of being active 18 months after HF. The phenomenological-hermeneutic approach was found a strength foregrounding the existential meaning of their experiences. The authors know of no other studies with this specific focus or doing interviews at this time-point after HF. Thus, it may seem a limitation that our discussion with relevant literature to a large extent was done using studies on experiences of being old and living with disability and chronic illness. However, it was a strength in several ways that the study was part of a longitudinal study. Firstly, a trustful relationship was developed over time, which particularly in aged adults embodying vulnerability is considered vital to avoid omission of important messages (39). Secondly, knowing participants through 18 months changed and enlarged the horizon of the researchers thereby allowing for a deeper understanding to emerge. Thirdly, repeated interviews made it possible for the researchers in the interview situation to refer back to former interviews, repeatedly questioning own pre-understandings and add trustworthiness to the findings. Fourthly, two former studies based on experiences of the same participants allowed the researchers to discuss the present study results with two former studies and consider changes over time. Further, trustworthiness of the analysis was strengthened from interviewing participants in their own homes; it was a possibility to see how they moved about in their familiar surroundings; they showed personal items and shared stories related to them with the interviewer, thereby adding to a deeper understanding of the meaning of being active in daily life situations.

Nine participants were included in the study, a sample size suitable within phenomenological-hermeneutic research traditions to reach in-depth knowledge (40) and avoid shallow interpretation (30). Based on the rich descriptions of participants experiences in this study transferability to aged adults without HF is possible when carefully considering what is recognizable in relation to context and to people´s living conditions. Therefore, the limitations from the study taking place in a country where healthcare and older-care services to a large extent are tax-financed; that all women in the study were widowed, while the two men were married; and that no participants were living in major cities should be taken into consideration. Aged adults living in other cultural settings with different social conditions and living in other geographical settings may have different experiences.

Conclusion

Taking aged adults´ lifeworld for given, the findings of this study pointed to several themes calling for a person-oriented stance to progress aged adults´ possibilities for being active during 18 months after HF. Aged adults feeling vulnerable seem to struggle on their own to avoid a sense of meaninglessness. Nuanced experiences of the meaningfulness of being active to be reflected upon were presented as well-being experiences of present-centeredness and possibilities to develop a feeling of gratitude; places connecting with past experiences; acknowledgement of personal capacities; possibilities to thoughtfully manage vulnerability through relieving the strain in everyday life and increasing a sense of self-confidence and safety; possibilities for sharing experiences with other people in a joyful atmosphere; respecting and acknowledging individual needs. Future research developing interventions to support aged adults in being active after HF should consider possibilities for facilitating experiences of meaningfulness. Testing interventions in relation to effectiveness should be supplemented by studies on aged adults´ experiences of meaningfulness being part of such interventions.

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7 Discussion

This chapter adding to discussion in the three papers is a discussion of selected findings answering the research question; followed by a discussion of the methodology and methods presented in chapter five.

Discussion of findings

In hospital and early after discharge after HF, aged adults are hoping for progress and struggling to find meaning in being active. The complications they embody (paper I, Table 2) are barriers for being active, and relying on help, feedback, advice, and support from HCPs and feeling encouraged and acknowledged are essential to maintaining courage. These finding corroborate with existing research on aged adults experiences after HF, which shows that during hospitalization, it is important to be confirmed that they are doing well and to receive praise from hospital staff (Bruun-Olsen et al., 2018; Gesar, Hommel et al., 2017). This study, in addition, underlines that the acknowledgement and praise they receive supports a feeling of safety, both in-hospital and after discharge (paper I). Feeling safe starting during hospitalization is vital to remain open towards possibilities and again finding meaning in being active (paper I). Our study shows that feeling neglected and misunderstood by HCPs, and not receiving the help and support they need to be active, aged adults feel helpless (paper I & II). Earlier research describe aged adults' in-hospital worries when HCPs placed too high demands (Wykes et al., 2009) or when they felt they are not being taken seriously or even ignored when in need of help (Malin Malmgren, Eva Törnvall, & Inger Jansson, 2014). We additionally point out that experiences of being neglected, e.g. given orders, being rushed, and suspected of being lazy, exist and can decrease aged adults' inner driving forces and reduce possibilities for finding meaning in being active. The present study draws attention to the observation that when cooperating with HCPs, a feeling of being treated respectfully is missing, e.g. helpers ignoring limitations and not respecting personal values (paper III), aged adults may feel undignified, unsafe, left on their own. The consequence may be the creation of a risky situation promoting falls, being prevented from being active (paper I & II), or exhaustion from trying too hard (paper II).

The finding in this study that the embodiment of several complications is experienced as a barrier when aged adults are struggling to find meaning in being active (paper I) is confirmed by earlier studies (Hallstrom et al., 2000; Jellesmark et al., Dec 2012; Olsson et al., 2007; Wykes et al., 2009;

Ziden et al., Jan 2010). Our study adds an overview of some of the embodied problems that are part of aged adults' lifeworld (paper I) and documents aged adults' experiences of how these problems can stop them from feeling safe and moving forward in a meaningful and taken-for-granted way. Earlier studies also document that in hospital and near discharge pain (Hallstrom et al., 2000; Hommel, Kock, Persson, & Werntoft, 2012; Malin Malmgren et al., 2014) and side-effects from the medicine can disturb the possibility to be active (Hommel et al., 2012), and we add that specifically when left on their own to manage side effects, the meaningfulness of being active is put under pressure. The finding is exemplified by Lene at the second interview, talking about her suffering due to side-effects during and after hospitalization and her wish to reduce her intake of morphine: "... [they said] I couldn't just decide that for myself. I replied that "*I cannot decide how many (pills) you give me, but I most definitely can decide how many I want to swallow"*. These findings point to an area of attention for HCPs in hospital and in communities.

Findings show that complications within the 18 months after HF increase the suffering and decrease the joy of being active (paper I`& III), put hope under pressure and may lead to staying at home from valued activities (paper II). Earlier studies describe feelings of helplessness and isolation (Jellesmark et al., Dec 2012) and feeling lonely (Gesar, Hommel et al., 2017) as a consequence of not being able to be active as they were before the HF. Our findings show that after HF, unable to embrace a wish to be active and feel self-evidently part of life, aged adults have experiences of hopelessness and losing courage (paper III). These findings support earlier research underlining that a special attention towards signs of depressed mood and hopelessness is called for (Bruun-Olsen et al., 2018; Griffiths et al., 2015; Jellesmark et al., Dec 2012; Ziden et al., 2008; Ziden et al., Jan 2010). Feelings of hopelessness and feelings of being out of control can lead to depression (Bruggemann, Nixon, & Cavenett, 2007) and have negative consequences for the possibilities of recovering well (Fredman, Hawkes, Black, Bertrand, & Magaziner, 2006).

New knowledge in this study is how aged adults living with complications after HF experience the meaningfulness of being active in the intertwined experience of well-being and suffering. Examples are; the complex dynamic relation between an inner dialogue of limitations and driving forces and their interaction with HCPs, physical surroundings and public services (paper I); feeling vulnerable being stretched between experiences of renewal and loss of courage (paper II); and how struggling to balance dwelling and mobility a feeling of the continuity of life is in the foreground while experiences of feeling vulnerable are always in the background (paper III). These findings add empirical evidence to the theoretical framework of well-being and suffering (K. Galvin & Todres, 2012). The suffering aged adults experience may be overwhelming, and they may be unable to fulfil a wish to be active and part of life and therefore withdraw from life sliding into feelings of depression (K. Galvin & Todres, 2012). The dynamic interrelatedness of aged adults' experiences described in the three studies point to areas important to consider for HCPs when helping aged adults to see possibilities within new life circumstances and remain active in a meaningful way. Additionally, keeping in mind that some of the complications aged adults are embodying may be modifiable, these should be carefully assessed.

The findings of the three studies show that for aged adults during the 18 months after HF the meaningfulness of being active is an experience of getting back to feeling like a dignified human being in mutual relationship, managing independently in everyday life. The value of feeling independent is in line with several studies on aged adults experiences after HF that describe being able to manage independently without help as a personal standard (McMillan et al., 2012), aged adults` hope for and struggle to be independent (Gesar, Hommel et al., 2017; McMillan et al., 2012; Ziden et al., 2008), and how a sense of self-esteem is essential to have a sense of having recovered well (Gesar, Hommel et al., 2017; Ziden et al., Jan 2010). New knowledge presented by this study is that the meaning of being active is restored in feeling dignified in the act of trying, persistently doing things, and feeling connected with personal capacities developed through life. Further, in this study aged adults' sense of meaningfulness during the studies changed towards also accepting limitations in present, everyday life conditions, thus encompassing a sense of dwelling (K. T. Galvin & Todres, 2011).

We confirm findings from earlier studies that aged adults are adjusting to moving more slowly, are considering whether to keep on fighting or to give up (Gesar, Hommel et al., 2017), and are adapting to using assistive devices and accepting more help (Robinson, 1999). This study adds the existential call for acceptance when restoring a sense of meaning in being active. Within the perspective of Heidegger's concept of the four-fold, to be active is only possible if we are capable of dwelling (Heidegger, 1971a). Keeping on struggling, searching for meaning primarily in feeling able, maintaining independency, and being able to do things can lead to suffering (paper II & III). Dwelling is to "save the earth" (Heidegger, 1971a) (p. 148) and maintaining its true nature, in this study equivalent to caring for the embodiment of vulnerability, e.g. by taking breaks (paper II), enjoying sitting in the sun (paper II), or receiving a massage (paper III). Struggling too hard can bring disappointment, exhaustion, and feelings of helplessness (paper II & III); and meaningfulness in being active may rely upon feeling connected with earlier life experiences, feeling content and grateful, and being at peace with just being and having lived a long life (study III). These findings point to the important of helping aged adults to be active in meaningful ways after HF. Focusing primarily on possibilities for progress and an ongoing struggle to manage independence may bring suffering. A better option may be to direct attention towards experiences bringing comfort and joy, supporting experiences of acceptance and feeling at peace.

Our findings acknowledge the significance of determination, being persistent, and trusting in own inner strength as vital part of aged adults' experiences of meaningfulness in being active (Olsson et al., 2007; Sims-Gould, Stott-Eveneshen, Fleig, McAllister, & Ashe, 2017; Young & Resnick, 2009) Moreover, findings point towards aged adults being active after HF is not only a matter of perseverance and individual choice. Understood with-in their four-fold, "the earth" in this study, is equivalent to the body, nurturing the possibilities for being active in meaningful ways, and to the self-confidence of being able to do what is important (Heidegger, 1971a p. 148). When the body is ageing and after HF, it becomes more vulnerable, and self-confidence in own ability to manage lessens, the body as "the serving bearer" (Heidegger, 1971a p. 147) withdraws. The findings show that with an experience of being more exposed to the vicissitudes of life aged adults have a need to feel safe. Earlier studies in line with our findings document unsafe situations and experiences of feeling unsafe preventing aged adults from being active and add to an experience of meaninglessness, i.e. fear of falling, feeling limited by pain and decline in mobility, moving more slowly, feeling insecure and abstaining from leaving the home (Gesar, Hommel et al., 2017; Jellesmark et al., Dec 2012; Ziden et al., Jan 2010), and the significance of assistive devices to be active (Griffiths et al., 2015; Jellesmark et al., Dec 2012; Robinson, 1999). This study shows the significance of place; the places where the aged adults find themselves influence the way they feel and their possibilities for being active (K. T. Galvin & Todres, 2011). The places where aged adults were used to being active have a different feel. Discharged from hospital, the feeling of being at home is disrupted, and aged adults have to learn how to feel safe moving around within and around their homes. Being in places without a sense of possibility and community with other people, being active can be meaningless and lead to suffering (paper I). Examples from the study are feeling isolated and unable after discharge waiting for modifications of the home, or feeling helpless not able to do anything but sit alone at home (paper I). The home and the vicinity that earlier was a place of promise and promoting possibilities to being active in a meaningful way have become restrictive spaces. Recently, an international consensus on factors to address when addressing sedentary behaviour underlines the significance of including environmental and home settings as well as public and healthcare services (Chastin et al., 2016). This study points to the significance of offering aged adults the right conditions to be active, thereby minimizing the domination of the HF and the complications aged adults embody, and supporting possibilities to be active in meaningful ways. Examples from the studies are, for example, the presence of assistive devices, discharged to a rehab centre (paper I), engaging in training to reduce adverse effects from complications (paper I & II), and the possibilities for seeing other people, for example, at a daycare centre (paper I, II & III).

Findings of this study point to the significance of being in places allowing for a feeling of being connected with earlier life-experiences and personal capacities (paper I & III). The findings are similar to a study on ageing in places where connections to the home, the neighborhood, and the community supported aged adults´ sense of identity, security, and social connections (Wiles, Leibing, Guberman, Reeve, & Allen, 2012). Findings from this study add new knowledge on how the connection with the physical environment is supported by routines (Nicholson et al., 2012). The three papers provide details about how aged adults in an interplay between own actions; receiving help from family and friends; and the physical environment thoughtfully find ways to be active in everyday life. Using their creativity, keeping on doing an effort, organizing their actions, avoiding exhaustion, finding possibilities for feeling comfort, and receiving training to learn how to move safely, aged adults after HF thoughtfully struggle to balance mobility and dwelling to be active in meaningful ways (paper I, II & III).

A finding becoming apparent from following the same aged adults during 18 months is that in awareness of life’s finitude the meaningfulness of being active is an appreciation of life possibilities. Earlier studies touch on how the existential concerns and feelings of being old are provoked by experiencing the nearness of death (Ziden et al., 2008), and how by realizing that permanent loss has taken place, the impact of age comes up close (Bruun-Olsen et al., 2018). In this study, talking about death was integrated into talking about managing in everyday-life, accepting death as a natural part of being old, a finding concurring with earlier research on living with frailty in old age (Nicholson et al., 2012). Adding the concept of the four-fold as a basic existential condition in human life (Heidegger, 1971a), new understanding is developed. Aged adults do not "darken dwelling by blindly staring toward the end" (Heidegger, 1971a p. 149). Findings show that being aware of the finitude of life the meaningfulness of being active is found in the appreciation of possibilities in life, feeling gratitude, and feeling connected with other people. What Heidegger named "the divinities" in this study is illustrating longing for something more to life than meets the eye, and mainly is an experience belonging with other people and the possibility to have new, different experiences (paper II & III). Earlier studies show the significance of practical support from family and friends to be active after HF (N. F. Taylor, Barelli, & Harding, 2010; Young & Resnick, 2009; Ziden et al., 2008; Ziden et al., Jan 2010), and shortly touch on the comfort and feelings of optimism when family and close friends are there to give support and encouragement (Young & Resnick, 2009; Ziden et al., Jan 2010). This study adds new and detailed knowledge on the existential experience of a sense of belonging and of feeling the mutuality with other people, and how essential these experiences are for aged adults to feel the meaningfulness of being active after HF. Experiences range from feeling connected with the world when receiving visits, being confined to the home after discharge from hospital (paper I); feeling natural part of a life-long relationships when sharing experiences and traditions (paper II & III); feeling energized from meeting other people e.g. at daycare centres or walking in the vicinity (paper I & III); and feeling safe meeting with neighbors on regular basis (paper I & III). The practical support aged adults receive is also a human relationship and a possibility to feel part of a community, and meeting and talking with people turns the attention away from limitations and loss in the nearness of death, allowing aged adults to feel deeply connected with being alive. The influence of social relationships on health is well established (Holt-Lunstad et al., 2010), and aged adults' possibilities for feeling mutuality and a sense of belonging is suggested to be a central part of HCPs assessments of need for help and interventions after HF.

To care for aged adults possibilities for being active in meaningful ways is to care for their possibilities as well as their vulnerabilities (Todres & Galvin, 2010), and to respect their values and standards even when these are not articulated in words (Barclay, 2016). Aged adults in this study tend not to speak up and ask for help; living up to values of managing without help they are at risk of struggling too hard on their own or giving up (paper II). A study on aged adults' experiences looking back on the recovery process after HF finds that because they do not know what they are missing, aged adults do not ask for help (Schiller et al., 2015). Trying too hard to manage puts aged adults at risk of unnecessary reduction of possibilities for the well-being of being active, increasing their health problems (Canvin, MacLeod, Windle, & Sacker, 2018). Based on our common human vulnerability in a world that is shared (Heidegger, 1962), caring for the dignity of aged adults beyond what they articulate in words is possible, and for HCP can be sought through sensitivity towards the lifeworld, reaching towards the "insiderness" of the individual (Todres, Galvin, & Dahlberg, 2014).

Discussion of the methodology and methods

This section contains a discussion of the methodology and methods described in Chapter 5. The methodology is discussed within four main areas 1) Acquiring a useful horizon, 2) Reaching for aged adults Being-in-the-world, 3) Applying a temporal perspective, and 4) Applying the hermeneutical circle. The methods used are discussed in relation to the data collection, the data analysis, and ethical considerations.

Acquiring a useful horizon

The phenomenological-hermeneutic approach of this study made it possible to explore aged adults' experiences of the meaning of being active as an interconnected and complex whole. Used inductively the framework of dwelling-mobility together with Heidegger's ideas on being-in-the-world served as a valuable horizon when trying to understand at a deeper existential level aged adults' experiences (Brinkman & Kvale, 2015). The theoretical framework of well-being built on, among other philosophies, Heidegger's ideas and concepts, as did this study. This connection between the philosophical foundation of the study and the theory used was a strength, securing internally coherent approaches to conducting the research (Carter & Little, 2007). The existential perspective was used to think with and to think about contributing to widen my horizon and see beyond what immediately presented itself for me in the interview situation and in the data, and to bring out what was hidden (Coffey & Atkinson, 1996 chapter 6). The framework on dwelling-mobility was used to understand meaningfulness acknowledging the intertwined experiences of suffering and well-being. Using Heidegger's ideas about the four-fold was a valuable pre-understanding to have acquired. His ideas sensitized my awareness of how being nearer to death, embodying vulnerability, being exposed when conditions for being active are changing influence on the meaningfulness of being active. This made it possible in this study to understand being active as an individual experience of meaningfulness as well as to capture what was universal (Morse & Field, 1995).

Reaching towards aged adults being-in-the-world

From an existential perspective the interview situation was a source of knowledge about aged adults´ experiences of physical activity as a part of their whole life. What was said was understood not only as the spoken word but being attentive and also listening for the deeper meaning behind the word (Heidegger, 1962). During individual, repeated interviews, aged adults spoke about their experiences of being active within the ontic realities of everyday life and revealed existential concerns about the meaning of being active.

Reaching towards understanding what it was like for aged adults to be active, an interview-guide was developed based on the existential framework, formulating questions in order to keep judgment and prejudices from dominating the interview. The questions were open ended, allowing for participants to talk about what was important for them and for new meanings to emerge other than my pre-understanding. This added strength to the credibility of capturing data representative of participants' experiences within their lifeworld but still within the horizon of the common interest of the subject of the interview (Brinkman & Kvale, 2015).

Informal dialogues served to establish rapport, which is a strength when interviewing aged adults feeling vulnerable (Kirkevold & Bergland, 2007). Spending time together with participants after the interviews and sharing experiences from their everyday lives added knowledge about their whole lives. Being in their own homes added nuances and insight about their possibilities for feeling at home (Heidegger, 1971a); noticing how they moved about and where and how they sat, the things they showed, and the places they spoke about in their close vicinity gave a deeper understanding of possibilities for comfort and activity. These valuable insights into their everyday lives supported the credibility that participants' horizons were included when interpreting what they were talking about.

Applying a temporal perspective

The longitudinal design allowed for viewing aged adults' stories within a temporal perspective, and each new interview was part of a continuous movement towards a new understanding. The repeated interviews added to the trustworthiness that the interpretation was arising from the participants' experiences. Each interview was an opportunity to get to know the participants better, acquiring a better understanding of the whole of their lives, thereby securing a useful horizon to understand the specific parts of their stories (H. Gadamer, 2013). For example, stories from earlier life could illustrate participants' essential life values. One participant's story about depending on her own will and being independent since being in her early teens, framed her present difficulties in accepting being dependent on help, and her struggles to stay independent at the edge of what she was able to manage. During the four interviews, these stories became part of her process towards accepting help as a natural part of becoming old. Viewing aged adults' stories within a temporal perspective was a strength, serving to illustrate the loss some of the participants were experiencing, and the human capacity to reach for the meaningfulness of being active.

A strength of the repeated interviews was that they provided the possibility to consider ethical ways to plan the follow-up interviews. Further, each interview was the chance to refer back to topics in earlier interviews, thereby correcting possible misunderstandings, such as a very short statement which I asked to have clarified to further understand the meaning it had and avoid misinterpretation. Additionally, building on the ongoing fusion of horizon between the researcher and each participant, different possibilities were considered to support the individual aged adult in telling about their lives and experiences.

Applying the hermeneutical circle

In phenomenological-hermeneutic research, the pre-understanding of the researcher is essential to consider during the interpretative process, and credibility in this regard was to provoke my pre-judices through the hermeneutical circle (H. Gadamer, 2013). A hermeneutical circle occurred through the interpretative process using a five- step method of meaning interpretation. These steps were a circular movement searching for patterns between the parts and the whole in relation to the individual participant, all participants, and any previous interview. For example a participant talking about childhood experiences of playing on the beach and the felt agility of the body then, gave a new perspective indicating that her present walks on the beach with a walker were not only being about fresh air and nature.

An additional circle was the dialogue with the co-authors of the study, discussing and questioning the partial understanding arising at different steps of the interpretation. These dialogues broadened the awareness of hidden prejudices, pointing to thinking that was too shallow, and developing a deeper understanding. This resulted in writing and re-writing findings until a coherent whole was developed (Fleming et al., 2003). Further, when findings were genuinely understood by co-authors, it confirmed that a trustworthy understanding had been reached (Smythe et al., 2008).

A third hermeneutical circle was when preliminary findings from the first two studies were presented in teaching for HCPs in the communities, and were used in group work between HCPs; the resonance or lack of resonance in the HCPs with the findings was taken to be a hallmark regarding whether the existential trustworthiness of the findings was achieved (Smythe et al., 2008).

A fourth hermeneutical circle was provoking the prejudices by means of reflecting on my professional and personal experiences, for example, those that derived from being a daughter and daughter in law of aged adults experiencing existential concerns when possibilities for being active were becoming increasingly limited.

Discussion of method

Data collection

Participants were sampled purposefully based on the pre-defined inclusion criteria. This was a strength that secured that participants had experiences related to the study aim (Sandelowski, 1995). The strength of the sample was that the participants represented variations in age and gender, family relationships, and residential status. This secured access to a diversity of individual experiences and provided unique accounts to form the basis for a rich and textured understanding of the meaningfulness of being active (Brinkman & Kvale, 2015; Crowther, Ironside, Spence, & Smythe, 2017; Laverty, 2003). It may be a limitation that all the women were widowed, except one woman who died after the first interview round had been completed. Further, results may not be representative of aged adults living in major cities. Acknowledging the high mortality rates among aged adults with a HF, it was a strength to have the possibility to meet with the majority of participants up to four times providing valuable data on experiences during the 18 months after a HF.

In this study, health-related issues, e.g. previous strokes, among participants had an impact on their ability to provide rich descriptions of their experiences, and some had difficulties talking at length and reflecting on their situations. It could be seen as a limitation that some participants were less articulate, saying little, and when asked about the meaning of specific experiences, it was difficult for them to answer. However, these thin descriptions when taking together with data from more articulate participants added valuable information and emphasized the significance of these experiences. Though leading questions are contrary to the ideal of an open attitude and probing aged adults to talk freely about experiences (Brinkman & Kvale, 2015), they were useful as part of the interview. Interviewing aged adults who were not used to talking a lot and were of few words, these questions on occasion encouraged them to expand on their experiences.

It was considered a strength that the method applied allowed the inclusion of this group of aged adults and secured that the sample represented not only those in the best of health. This secured that the picture of the phenomena was more complete (Kirkevold & Bergland, 2007), bringing valuable understanding on older adults' vulnerability and their struggles to be active in a meaningful way.

The presence of a close relative during some of the interviews turned out to be a strength. Firstly, the presence of close relatives brought comfort, lending a familiar atmosphere to the interview situation. Secondly, relatives talked about other details and situations and reflected on changes in their life situation, which encouraged participants to talk more, thereby contributing to a richer account. Joint interviews are considered relevant when researching experiences of health and illness (Sakellariou, Boniface, & Brown, 2013), and acknowledging the shared experience of illness in families, the relatives' accounts became part of my horizon and were useful to better understand a participant's whole situation (Norlyk, Haahr, & Hall, 2016).

The ideal of a good interview may be that participants stick to the phenomena under study and the interviewer should avoid digression (Brinkman & Kvale, 2015). However, giving space and time for participants to talk about memories and stories of past experiences helped to meet their horizons during interpretation.

Using individual interviews was found appropriate to the exploration of aged adults' experiences of the meaningfulness of being active. Focus group interviews may bring forward new issues in the dynamics of being in a group; however, they were not found appropriate considering participants health concerns, i.e. difficulties speaking, decreased eyesight, and impaired hearing (Morgan, 1997).

Data analysis

The thorough data analysis was a strength. Using a five-step process of meaning condensation as a method (Brinkman & Kvale, 2015), the hermeneutical circular process of interpretation was applied and allowed a fusion of horizons to occur through dwelling with data (Heidegger, 1971a). Following the structure firstly secured the discipline to sustain a thinking that stayed grounded in the data, allowed dwelling with the words to let a new meaning emerge, secured a dialogue with philosophical writings, and served as a basis for communication with the research team about the findings. Repeatedly listening to how participants spoke during the interviews, reading field-notes documenting the immediate impression of participants, and getting an impression of participants that was not expressed in the spoken word, supported the credibility of a fusion of horizons to occur and that findings remained close to the lifeworld of participants. By referring back to earlier interview transcripts and notes, the researchers acquired a horizon that included the participants, thereby strengthening the trustworthiness that the findings were depended on the experiences of the participants.

Considering that the data were synthesized, abstracted, and decontextualized, member checking was not considered appropriate (Morse & Field, 1995; Sandelowski, 1993). Credibility was ensured by detailed descriptions of participants' individual experiences in relation to themes developed in each study (Shenton, 2004), and quotes from participants visualized the connections between themes and participants' experiences (Sandelowski, 1994).

Ethical considerations

Overall, the opportunity of giving voice to a group of aged adults not speaking up and expressing themselves was seen as a moral obligation, securing that their interests were taken seriously (Iphofen, 2005; Orb et al., 2001).

To be interviewed about existential concerns could potentially be a distressing situation for aged adults with suddenly changed, limited or lost possibilities for being active in everyday life. Participants always had the choice to leave the study. Oral consent to stay in the study, anonymity, and the right to decline answering questions were re-confirmed prior to each interview. On some occasions, one participant asked for the recorder to be turned off, and before recording was restarted, she was reassured that she would not be recognizable when data from the interview was used.

I built a relationship with participants by spending time with them, talking with them prior to starting the interview, and conducting a de-briefing after each interview. Dialogue with participants after the interviews tended to become longer from interview to interview. Participants' trust in me seemed to grow; they wanted to talk about experiences not relevant for answering the research question or showing things we had been talking about. Becoming more familiar with participants, special attention was paid towards avoiding taking advantage of participants' trust. The wish to encourage openness was balanced by the risk of urging participants to tell more than they wanted to relate (Fog, 1998).

It was a strength that ethical considerations were taken to avoid making participants feel unease or unable to live up to the requirements of the interview situation (Fog, 1998). If participants displayed signs of discomfort, for instance, if they were reluctant to have eye contact, sat restlessly in their chairs; or answered questions reluctantly, the researcher made room for pauses and a change of subjects to occur. During the interviews, telling participants that I appreciated what they were telling me reassured them that the stories they were telling about ordinary everyday situations were valuable.

During the interviews, participants wandered off into stories of their earlier lives; listening and being attentive to these accounts was an opportunity to confirm that they were dignified human beings who had been active during their lives, and were considered not just as vulnerable and dependent aged adults (Kirkevold & Bergland, 2007).

8 Conclusion

Using a phenomenological-hermeneutic approach, this study provides knowledge about aged adults’ experiences regarding the meaningfulness of being active after a HF, and how this changed during the 18 months. In this conclusion, the possibilities for feeling meaningfulness are emphasized and experiences of meaninglessness are scarcely touched upon.

In hospital and near discharge, barriers and facilitators for being active in everyday life exist in a dynamic relation between aged adults’ own inner dialogue and the relationships they are building with HCPs while struggling with complications in the places where being active is meaningful. Because of their feeling of vulnerability, it is essential for aged adults to feel safe. Feeling safe is related to cooperation with and feeling acknowledged by HCPs and feeling supported by the physical environment and community services. The findings illustrate the significance of the actions of HCPs with regard to helping aged adult to feel supported and confident when struggling to find meaning in being active.

After one year, vulnerability is a central existential concern, calling for a manageable everyday life. Feeling stretched between experiences of well-being and suffering, the meaningfulness in being active is related to feeling safe, feeling connected with other people, and the possibilities for feeling comfort. Struggling too hard can lead to suffering and maintaining a sense of dignity in identity is searched for through a balance between what is possible to endure and what is possible to accept. The findings illustrate that by encouraging bodily strength and self-confidence physiotherapists help aged adults to make sense of being active.

Eighteen months after the HF, the meaningfulness of being active changes in aged adults from a sense of identity mainly related to being able to keep on doing what was possible before the HF towards reconciliation with limitations and loss of possibilities. Feeling vulnerable always is in the background and aged adults´ well-being experiences are intertwined with suffering. The meaningfulness of being active is related to aged adult’s present experiences of their own being as a part of a whole life. Aged adults feel gratitude for the possibilities available for being active, feeling supported by own thoughtfulness and earlier life-experiences, and have a sense of moving forward and being part of life while feeling connected to other people.

For aged adults, the meaningfulness of being active is an experience of feeling like a dignified human being in mutual relationships with other people during the 18 months after a HF. Meaningfulness is experienced in a dynamic relation between a sense of identity, meaningful relationships, feeling connected with the continuity of life and with places supporting possibilities for doing things. Feeling dignified in identity changes during the18 months after a HF from primarily a sense of one´s own capability towards also encompassing a feeling of being connected with earlier life values, feeling content and grateful, and being at peace with just being and having lived a long life. HCPs and municipality services are essential for aged adults struggling to be active in meaningful ways; however, aged adults tend not to ask for additional help. Aged adults may endure too much or settle for too little. Struggling to feel dignified and to be independent in everyday life aged adults balance the meaningfulness of being active with a need to feel at peace in experiences of dwelling and the need to feel energized in experiences of mobility. Aware of life’s finitude, feelings of mutuality with other people, possibilities for sharing everyday-life experiences, and having new experiences are vital. Being in places with the possibility to experience the well-being of feeling at home and connected with their whole life, it is meaningful to be active. The actions of HCPs and availability of municipality services have an influence on whether experiences of well-being or experiences of suffering are foregrounded.

9 Implication for practice

The ontological knowledge from this study can be used in health care practice and thereby add a human perspective to epistemological-based patient-oriented practice. Findings from this study indicate that experiences of well-being are a resource for aged adults and can provide a basis for HCPs to approach the existential concerns aged adults have after a HF. As a starting point, rehabilitation and other interventions should take aged adults` experiences of what is meaningful for them.

This PhD study is followed by a PhD-study reference group with representatives from the hospital and the four cooperating communities. Here application of study results is planned to be presented in thematic afternoon meetings with HCPs, providing a foundation for reflecting on aged adults' possibilities and challenges after HF related to the specific context of the hospital and each municipality. Continued collaboration and involvement in practice development is an obvious possibility.

Near discharge from hospital, aged adults are particularly vulnerable and need to feel safe and dignified in the physical environment and in their relationships with other people. Planning discharge in cooperation with communities as well as addressing family and friends are recommended. A discharge plan should include the establishment of a supportive physical environment and possibilities for meaningful human relationships offering practical and human support.

After ending rehabilitation, aged adults tend to struggle on their own and not ask for help, and they may experience that they are sliding into a state in which they are losing courage. A community pro-active effort, e.g. implementing follow-up visits on a regular basis during the 18 months after HF, will provide the possibility to assess aged adults' well-being and the possibilities for being active in meaningful ways

A number of challenges have been identified in this study. Based on the experiences of aged adults`, the recommendation is to develop a feasible and appropriate screening tool sensitizing HCPs towards the life-world of the individual; to be used e.g. in hospital when planning for discharge, on community follow-up visits or on existing preventive home-visits. Considering how experiences of meaningfulness in being active can be supported, suggested areas of interest are as follows:

- whether meaningful relationships with other people and new joyful experiences are present
- whether the complications aged adults experience are modifiable
- whether the strain they experience in their everyday lives can be relieved
- whether the possibility to be active in a safe way in the home and in preferred places in the vicinity is possible
- whether possibilities for comfort and feeling nurtured exist
- whether cooperation with HCPs is based on mutual respect

Aged adults may be few of words, and experiences gained from doing this study indicate that knowing the individual over time allows for understanding what they are talking about within a wider horizon. Continuity with regard to the same HCPs meeting with the same individual is recommended.

10 Implication for further research

This study has produced new knowledge on the meaningfulness of being active during the 18 months after HF. However, aged adults had difficulties recalling experiences during hospitalization. The present study has shown that feeling safe and being acknowledged are vital experiences that support aged adults` feelings of confidence. A qualitative in-hospital observation and interview study is needed to explore aged adults experiences of how HCPs support experiences of well-being and meaningfulness, e.g. feelings of safety, acknowledgement, and self-confidence.

Experiences of well-being in this study are found to be vital resources for aged adults struggling to be active after a HF. The study recommends future research focusing on how rehabilitation with a well-being perspective can supplement rehabilitation existing in hospital and communities. Based on findings in this study, interventions can be developed, and feasibility, appropriateness, meaningfulness, and effectiveness can be explored and tested.

Doing this study revealed that aged adults can be less articulate and that the presence of a relative during the interviews can provide additional knowledge useful for understanding the challenges aged adults experience after HF. Joint interviewing, repeated interviews, and observations are recommended as relevant methods to be used when aiming to acquire a deep understanding of aged adults' experiences.

A number of the challenges experienced by aged adults after HF have been identified, e.g. the complications they must deal with such as exhaustion, the lack of assistive devices or modifications in the home after discharge, barriers in the outdoor environment, and feelings of being neglected by HCPs. We need studies on the extent of these challenges as well as on studies that explore how these challenges affect aged adults' possibilities for recovering their well-being and functioning.

For aged adults recovering from a HF, family, friends, and neighbours are an essential part of their everyday lives. Studies on aged adults experiences of these relationships and how they support aged adults possibilities for being active in meaningful ways are called for.

English summary

Background: In Denmark 10,000 aged adults are estimated to sustain a hip fracture (HF) annually. Physical activity is vital and a source of meaningfulness for aged adults. After a HF, the possibilities for being active change, and despite rehabilitation, aged adults are inactive. Barriers to being active after HF are poorly understood, and an existential perspective on aged adults' experiences of being active after HF is lacking.

Aim: The aim of this study is to explore and describe old adults' experiences of meaningful physical activities during the first 18 months after a HF.

Design, methodology, and methods: Using a phenomenological-hermeneutical approach and adopting an existential philosophy and a theoretical theory of well-being, the thesis has a longitudinal design. An evaluation of four individual interviews of the same aged adults is presented in three empirical studies. The interviews were transcribed and analysed using a hermeneutical interpretation.

Participants and context: Thirteen aged adults between 70 and 92 years of age with pre-fracture dependency on help or assistive devices agreed to talk with me in their homes four times after discharge from hospital: at two weeks (n=13), six months (n=11), one year (n=9), and 18 months (n=9).

Findings: In hospital and near discharge, barriers and facilitators exist in a dynamic relation between aged adults own inner dialogue and the relationships they are building with HCPs while struggling with complications in the places where being active is meaningful. After one year, vulnerability is a central concern. Being stretched between experiences of well-being and of losing courage, the meaningfulness of being active is related to feeling safe, feeling connected with other people, and possibilities for feeling comfort. After 18 months, the meaningfulness of being active is a feeling of well-being related to feeling connected with the continuity of life while feelings of being vulnerable are always present in the background.

Conclusion: For aged adults, the meaningfulness of being active during the 18 months after a HF is an experience of feeling like a dignified human being and having a sense of belonging in mutual relationships with other people in everyday life. Aged adults tend to not ask for help from health care professionals and municipality services when they need it and struggling to balance experiences of peace and acceptance with experiences of possibility, they may endure too much or settle for too little. Meaningfulness in being active in everyday life changes from primarily feeling dignified in a sense of one's own capability towards also encompassing a feeling of being content and grateful.

Danish summary

Baggrund: Det estimeres, at 10,000 ældre danskere årligt må udholde at erhverve sig et hoftebrud. Trods rehabilitering ændres mulighederne for at være aktive efter et hoftebrud, og inaktivitet er almindelig. Barriererne er dårligt kendt, og et eksistentielt perspektiv på at være aktiv efter hoftebrud mangler. Særligt mangler der viden om oplevelser, der ligger ud over et år efter hoftebruddet.

Formål: Formålet med studiet er at undersøge og beskrive ældres menneskers oplevelser af meningsfuld fysisk aktivitet i løbet af 18 måneder efter et hoftebrud.

Design, metodologi og metode: Undersøgelsen har et longitudinelt design, og anvender en fænomenologisk-hermeneutisk tilgang, samt bruger en eksistentiel teori om velvære. Fire individuelle interview af de samme ældre mennesker præsenteres i tre empiriske studier. De transskriberede interviews analyseres med brug af fortolkning.

Deltagere og kontekst: Tretten mennesker i alderen 70 til 92 år, der før hoftebruddet var afhængige af hjælp eller gang-hjælpemiddel, aftalte at mødes med mig i deres hjem to uger (n=13), seks måneder (n=11), et år (n=9) og 18 måneder (n=9) efter udskrivelsen fra hospitalet.

Fund: Under indlæggelse på hospital og omkring udskrivelse har ældre mennesker en indre dialog om barrierer og facilitatorer for at være aktiv på meningsfuld måde. Dialogen foregår i et samspil med fagpersonalet, komplikationer efter hoftebruddet og de omgivelser de befinder sig i. Efter et år er egen sårbarhed et centralt anliggende. Udspændt mellem oplevelser af velvære og oplevelser af at miste modet er meningsfuldhed forbundet med en følelse af sikkerhed, at føle sig forbundet med andre mennesker og mulighed for at føle sig godt tilpas. Efter 18 måneder er meningsfuldheden i at være aktiv at opleve velværet ved at føle sig forbundet med livets kontinuitet, mens oplevelsen af egen sårbarhed altid er til stede i baggrunden.

Konklusion: Samlet set er meningsfuldheden i at være aktiv gennem 18 måneder efter hoftebrud en oplevelse at være et værdigt menneske med en følelse af at høre til og være del af gensidige relationer i hverdagen. Ældre mennesker med hoftebrud har det med ikke at spørge om hjælp fra sundheds personale og efterspørge serviceydelser fra samfundet. I bestræbelserne på at afbalancere oplevelser af fred og accept med oplevelser af muligheder, kan de udholde for meget eller stille sig tilfreds med for lidt. Oplevelsen af meningsfuldheden i at være aktiv i hverdagslivet ændrer sig fra primært en oplevelse af værdigheden i at være-i-stand-til hen imod også at omfatte en følelse af at være tilfreds og taknemmelig.

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