The influence of the environment on participation subsequent to rehabilitation as experienced by elderly people in Norway

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Abstract

The aim of this study was to illuminate how the environment may influence participation among elderly people who have undergone community-based rehabilitation in Norway, after an acute illness or accident. Fourteen persons over 65 years of age were selected with the specific intention of gaining a variety of ages, both genders, and people living in different kinds of housing. Three focus groups were established and repeated interviews were held with each group. A constant comparative analysis was used to analyse the data. The main finding was that the participants experienced pressure from their environment to concentrate on performing the most necessary daily activities rather than on participation. Three main encounters with environments seemed to be important for this: encountering people and society, encountering private and formal assistance, and encountering occupation. The support that the participants received from family and friends was more important for their participation than having accessible physical environments. The findings suggest that occupational therapists must consider themselves to be part of a societal environment that can hinder participation.

Key words: Community living older adults, community rehabilitation services, disability, focus-group methodology, grounded theory, ICF

Introduction

Participation in meaningful occupations and staying active are known to promote physical and mental health, prevent illness, and be important for successful ageing (1,2). There is also evidence that elderly people wish to and do continue to participate in society throughout their lives (3,4). Participation in society is also stated to be the main aim for rehabilitation services, in making participation the primary goal of rehabilitation, and its value has been recognized internationally and nationally (5,6).

Illness and reduced functional ability are often considered to be the main reasons for elderly people to give up participation (7). However, several studies support the idea that external factors such as environments can also represent obstacles to the participation of elderly people (7,8). In particular, research has found that physical environments influence the possibilities that elderly people with reduced functional ability have to perform daily activities in their homes (9,10). It is also known that young people with disabilities recount how environmental factors, like the attitudes of other people, the healthcare, service and certain policies, have an impact on their opportunities to participate in society (11,12). It can therefore be assumed that older people with disabilities might also experience an influence from the non-physical aspects of the environment. Since research related to elderly people with disabilities has concentrated mainly on describing the physical environment, little is known about how these people experience the influence of social environments, including societal environments and the attitudes of others. This knowledge is important for rehabilitation services that aim to enable participation. The present study focuses on how different factors such as physical, social, and attitudinal aspects of the environment may influence...
The interaction between individuals and their environments has been the subject of several theoretical models (13–18). While some of these focus on the influence of the environment on human development (17), others describe the impact of the environment on the individual's opportunity to perform occupations (13–16) or to participate in society (14,19). Yet others concern the disablement process and the influence the environment has on this (18,19). Common to these models is the perspective that the environment is composed of a multitude of factors that are external to the person such as physical, social, and societal environments. In general, though, some environmental factors are considered to depend on the individual, e.g. encountering others face to face, such as other persons and physical environments, while the concept of the societal environment embraces structural conditions, such as culture, attitudes, legislation, and healthcare systems (14,19). To further develop theoretical knowledge concerning the interaction between the individual and his or her environments empirical research on how the different factors may influence participation is needed.

Participation is closely connected to the environment (2,14,19). Fougeyrollas describes social participation as the result of an interaction between a person and his/her environment. In occupational therapy theory, occupational participation is conceptualized as those activities or tasks that a person is engaged in within his/her environments (15). According to the International Classification of Functioning, Disability and Health (ICF) (19), participation is described as involvement in a life situation where involvement incorporates taking part, being included or engaged in a certain area of life, being accepted, and having access to the resources needed (19). This understanding of participation embodies the individual’s right to participate in society with his/her right to control and conduct his or her own life situation (20). Since this study focuses on participation within environments, the ICF has been used to conceptualize participation as well as environment. According to the ICF, environmental factors make up the physical, social, and attitudinal environment in which people live and conduct their lives, incorporating both individual and societal environments (19).

Empirical research demonstrates that environmental factors can be the main hindrance to the participation of elderly people with reduced functional ability. Lilja (10) and Iwarsson (9) found that accessible physical environments in the home or in the community are of importance to ensure that elderly people are able to get out of their homes. Studies also show that the absence of an independent means of transport and giving up driving can form a barrier that hinders older people from participating in leisure activities outside their homes (21,22). Several studies have documented how the participation of disabled people in society is often hindered by physical environments (23,24), whereas social environments tend to make participation easier (25). Support from family and friends have been identified as an important environmental factor for both young and old people with a disability as well for longevity among the elderly population (26,27). However, among young people with a disability Li & Moore (11) found that attitudinal barriers were sometimes more difficult and time-consuming to cross than problems associated with physical environments. For completeness, it is worth mentioning that research concerning attitudinal barriers among elderly people in general has concluded that negative attitudes towards the ageing population may limit older people’s participation (28). Last but not least, the healthcare system may limit the participation of people with a disability (29).

Environments can be seen as an important facilitator for encouraging an active elderly population in general and, more specifically, for increasing the participation of older people with reduced functional abilities but they can also be a hindrance to participation. However, as much of the empirical research has been conducted on groups of young people with disabilities, or on studies that focus either on the physical environment or on other specific social and societal environments, there is a need for more knowledge about how elderly people with a disability perceive the interplay between different environmental factors to influence their opportunities to participate. This knowledge is important for a rehabilitation service that aims to promote participation. Hence, the aim of this study is to illuminate how the environment, in terms of physical, social, and attitudinal aspects, may influence the participation of elderly people with reduced functional ability after an acute illness or accident.

**Material and methods**

**Design**

The study was designed as a focus-group study with the intention of encouraging the participants to explore and discuss the issue of environmental influence in their own terms (30). The focus-group methodology was chosen because this method is
suitable to gain understanding of how participants make sense of and discuss the topic of interest. Three focus groups were established. In order to capture the complexity of environmental factors three focus-group meetings were planned for each of the groups in addition to a fourth follow up (30).

The studies were approved by the Norwegian Social Science Data Service (NSD), the Regional Medical Ethical Committee and The Ethical Committee at the Karolinska Institutet.

Participants
The participants were selected by purposeful sampling (31). People with aphasia and memory deficits were not included. The participants differed in terms of their age, gender, the type of housing they lived in, the time that had lapsed since the illness or accident, and the types of rehabilitation received. All participants were elderly persons over 65 years of age for whom rehabilitation services had been provided by the community healthcare system after the sudden onset of illness or subsequent to an accident within the two years prior to the study. The first group of five participants had received rehabilitation services at a day care centre and they had experienced being disabled for between one and five years. The second group consisted of four participants who had received rehabilitation services in their homes during the two-year period running up to the start of the study. In the third group, five persons participated who had had an illness or accident two to four months previously. The rehabilitation team in a health and social welfare district identified potential participants, and those who consented to participate were included.

Altogether, 14 elderly persons took part, 6 females and 8 males. Their ages ranged from 70 to 89 years with a mean age of 76. Seven participants lived on their own while the rest lived with a spouse or with relatives. All participants belonged to the same health and social welfare district, but they lived in different suburban areas in a city in Norway. Half of them lived in private houses, and half in apartment buildings. Further, all participants had family such as children, grandchildren, or a brother or a sister living in the same part of the country. Twelve of the 14 participants received formal help, e.g. from a home-help or a district nurse. All of them had received occupational therapy during their rehabilitation.

Data collection and procedures
The focus-group meetings took place at a municipality centre. Each session lasted two hours including refreshments. Initially the groups met every other week, then after three sessions they met once more 10 weeks later. The first author, who is referred to as the moderator in the discussion below, moderated all group sessions, while an assistant (henceforth called the assistant), who was an experienced healthcare professional, took care of the practical arrangements and summarized the main themes at the end of each interview as suggested by Krueger (32). The interview guide was centred on three main themes: physical, attitudinal, and social environments inspired by the description of the environmental factors in the ICF (19). Questions that were asked could be for example: “You have all experienced impairment after an illness or accident; do you think people look upon you differently after that?” “How come they do or do not?” “Have you stopped participating in any activities lately?” “In that case, what are your reflections on this?” The moderator encouraged the participants to talk about and discuss concrete situations in which they encounter different environments, such as what going shopping is like or what happens when the home-help arrives. The participants were explicitly encouraged to recount their experiences and then to elaborate on them and swap stories (33). The discussion centred on how they perceived different environmental aspects as influencing their opportunities to perform activities and participate in society. In particular, participants were encouraged to share both similarities and differences in views, with no claims of consensus. The moderator also posed questions that had been raised in one group to the other groups and

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suggested hypotheses that one group had come up with to the others. After each group session, the assistant summarized the discussion and the participants had the opportunity to comment on or confirm the main issues. After three focus-group meetings had been conducted for each group, the data seemed to be saturated. However, after approximately 10 weeks, a fourth session was held with each group to present the preliminary findings and invite the participants to discuss them. The data from the fourth session were then included in the analysis. All focus-group interviews were tape-recorded and transcribed verbatim by the first author.

Data analysis
The data were analyzed following the guidelines for the constant comparative method (34). First the interviews were read several times, then the main themes of the interviews were compared with the themes identified by the assistant in a summary of a tape-recorded discussion between the researcher and the assistant that was made after each session (35). A detailed line-by-line analysis was the first step of open coding intended to open up the text and generate initial categories (34). By asking questions such as “What is going on?” of the text, the initial categories emerged. These categories were assigned in-vivo codes, such as concrete environments (e.g. the home and shops), activities and participation (e.g. hobbies and shopping), and conditions or consequences (e.g. feeling lazy or tired). Then new questions were asked of the text, such as “How do the participants experience their environment, and what does this mean?” In this phase, the software program “OpenCode” was used to manage and revise the emerging categories (36). Each code was constantly compared with the other codes to identify similarities and differences, and with the interview transcripts to ensure that no data were left out. Next, in the axial coding, codes that seemed to belong together were grouped. The paradigm model, which identified conditions–actions/interactions–consequences, was used to investigate the relationships between the categories (34). Memos were written, sorted out, and used throughout the analysis. In the last phase, a story line was written around the emerging categories, which helped to develop an understanding of the participants’ experiences of their encounters with their environment. From this, the core category “environmental pressure towards withdrawing from participation” emerged as the category that most truly embraced the essence of the participants’ experiences.

Trustworthiness
The participants had an opportunity to comment and elaborate on the preliminary findings, as well as on the main themes identified in the summary by the assistant after each focus-group interview. Further on, peer reviews (31) were undertaken by colleagues within the health and social welfare district and a group of doctoral students and researchers, and feedback was received. Codes and categories were discussed continuously between the authors until a consensus was reached (31).

Findings
Three categories were found to be dominant for participation among the study participants. These categories were revealed in three different types of encounter between the participants and their environments: Encountering people and society, encountering private and formal assistance, and encountering occupation. In discussing these encounters, the respondents experienced different influences that came to govern their participation.

Encountering people and society
Overall, the respondents expressed satisfaction with their encounters with people and society, even though they had given up many previously important occupations. This contentment, however, seemed to be conditioned by certain aspects that gave the contentment a strong character of environmental pressure as described in the following.

Not being a burden. The respondents were content as long as they could manage their primary daily activities, such as taking care of themselves and their household, without being a burden on their families—even if this meant giving up other occupations, such as participation in leisure activities. Ideally, they wanted to be independent of both their families and the healthcare system. Because of this, they put a considerable amount of effort into maintaining these occupations, and they preferred to pay for private services rather than be a burden on their children. Even if the decision to leave the home they had lived in all their lives to move to a more accessible apartment opened up the possibility to participate more, this decision was often motivated by a wish not to be a bother to their families. One female respondent was very content after moving and said: “Now I can manage on my own. I can walk to my mailbox, and go out shopping—it’s kind of a new life. The children must live their own lives.” The importance of assistive devices as facilitators of
primary daily activities was emphasized, and even if performing these activities demanded a considerable amount of energy, the participants felt that they had to concentrate on them and gave up participation in other occupations. As long as they could avoid bothering others and they could maintain their independence, this achievement itself was sufficient to make them content.

Not being worse off. Another reason the respondents gave for being content was evident in the comparisons they made between their own situation and that of others. In spite of the fact that they had different illnesses and were unable to participate in occupations as they had before, they always knew of other people who were even worse off. They considered being frail and giving up participation to be a normal condition of life for elderly people. Some were lucky and continued to be healthy, they felt, but illness and accidents were perceived to be an aspect of life in old age. One male participant who had had a stroke said: "Bad luck is bad luck. That's life!" Consequently, the participants adjusted to their current situation, confident in the knowledge that there were always others who were worse off. The respondents also recounted how they felt content because they could look back on their lives with satisfaction. They had participated and had their share of life, they said.

Encountering helpful and friendly attitudes. Yet another reason for the respondents’ feeling of contentment was that the people they encountered face to face, whether in the shops or in the healthcare system, was friendly and helpful. The respondents’ impression was that, during recent years, people had developed a more helpful attitude towards elderly people, especially when impairment was obvious as, for example, when a walking aid was apparent. Healthcare staff were also described as being both friendly and positive, even though some of the participants had experienced the feeling that they were being patronized. They explained that physical barriers in the environments were not an important issue for their participation because they felt confident that the people they met would be helpful and friendly. Hence, finding someone to accompany them when going to the theatre or travelling, for example, was more important to them for their continued participation than having accessible physical environments.

Society’s expectations. Overall, the participants’ expressions of contentment seemed to be double-edged: on the one hand, the data showed that the respondents really felt a genuine sense of contentment when they met people face to face but, on the other, they also believed that the attitude of society was that they ought to be content. Politicians and the media seemed to be primarily responsible for giving the respondents this feeling. Even though none of the participants felt that either the politicians or media directly influenced their daily life, the politicians were the ones who gave the impression that elderly people were no longer required. One respondent said: "It’s as if they [the politicians] just want us to push a button, and disappear.” Many of them said that, for this reason, they hesitated when they needed to complain, especially where services intended for elderly people were concerned. One respondent said: "When you are lucky enough to receive help to have a shower and get dressed, you feel that you cannot complain.” Because of this, they were also reluctant to make demands concerning the opportunities they were given to participate in leisure and social activities. Instead, they had to content themselves with the way things turned out, thereby confirming the image they held of their generation, i.e. that it makes fewer demands than the next generation.

Encountering private and formal assistance

After their accident or injury, the respondents had, overall, become increasingly dependent on assistance from their families and from the social health and welfare system. From the data, it became evident that private assistance (individual environments) and formal assistance (societal environments) had an impact on the participants in different ways.

The family facilitates participation. Not surprisingly, contact with the family structured the respondents’ daily lives, through regular phone calls and visits. In particular, the respondents themselves were very much engaged in their family life and in fulfilling their roles as, for example, grandmothers or great-grandfathers. Consequently, they shared stories about taking part in birthday parties held for their grandchildren and, even, watching children’s cartoons on television to prepare themselves for discussions with a great-grandchild. When, in spite of all their efforts to be independent, the respondents needed assistance from their family, the assistance seemed to be provided in a manner that gave them the feeling that these activities were something they participated and collaborated in. For example, the family members and the respondent went for coffee after doing the grocery shopping together, or had a family gathering when the gardening was finished.
Consequently, the way in which the assistance was given led them to feel that they had a part to play in the activity as a whole, rather than being the recipient of an obligation, and this helped them to maintain control of their daily life.

The healthcare system: a time-consuming thief. Although the respondents found the assistance from the healthcare system to be important because they needed it, receiving this assistance demanded a considerable amount of time and energy from them: not only did they need to spend time receiving the services but they also spent time waiting. For example, the respondents talked of waiting for a referral to a specialist or for the occupational therapist to assess their need for assistive devices. Then they applied for and waited for the assistive devices to arrive. As one respondent said: “We spend so much time waiting: there is always an appointment, then we must order a taxi, and then we have to wait: Wait for the home nurse to turn up; wait for a referral to the physiotherapist. That is the way we spend our day. I get exhausted and spend too much energy on this.” Another respondent exclaimed: “We are old; we don’t have much time left to wait!” Consequently, they sometimes had to put aside their hobbies or appointments with friends during these exhausting waiting periods. They also said they had experienced that the healthcare system was making them “do extra laps” in addition to whatever strenuous course the illness itself might take. This metaphor was introduced by one respondent who said: “It seems as if we have been given a variety of extra laps after we have been ill.” For example, several of participants had disabilities that could be compensated for by adapting their physical environment. However, getting adaptations installed involved contact with what they called “the problematic bureaucracy”. Getting a handrail fitted to the stairs at home, for example, involved making several different applications. According to one respondent, the bureaucracy had “a strange way of making easy matters difficult”. Since they spent a considerable amount of time waiting and invested effort in what they felt to be a struggle with bureaucracy, many of them expressed feelings of being worn out, which forced them to put valued engagements aside. Consequently, the “assistance” provided by the healthcare system could be double-edged and partly experienced as a hindrance to participation.

Adapting to regulations in the healthcare services. When the respondents needed assistance from the healthcare system, its availability was determined by politics and the services were allocated by the administration. Because of this the respondents told of how they had to adapt their lives to fit in with, for example, the delivery of assistive devices or the arrangements for rehabilitation services. They felt obliged to accept the request made of them to stay at home during certain time periods when the home-help did their work, for example, even though this might interrupt their daily routine. The respondents worried about the summer vacation period when all “the barbarians arrive, the substitutes who don’t know anything”, as one of them put it. The seemingly never-ending organizational changes in the healthcare system diminished the respondents’ possibilities to participate in the decision-making concerning their own daily lives. Adapting to the limitations of the system meant they had to relinquish their autonomy and participation in terms of control of their own daily lives.

Encountering occupations

The consequences of encountering occupations per se also emerged in the data as an external factor that influenced participation. When, for example, the participants described occupations they wanted to take part in, many of them talked about outdoor occupations such as skiing, bicycling, and hunting, all of which are important leisure activities in Norway. However, these occupations had become too demanding for them, even when the physical environment had been adapted. Rather than referring to isolated aspects of the environment or body functions, they said that, “all the small things added up are exhausting”\(^\text{1}\); these contributed to their reduced capacity and disrupted their familiar former daily routines. Furthermore, the fact that they felt that they lacked the bodily control required to meet the demands of certain occupations was considered to be another of the exhausting disruptive processes that seemed to change their previously smooth daily lives. One of them said: “Before I became disabled I just managed everything without thinking about what I was doing. Now everything is so strenuous.” The burden of striving with all the small things that together hindered their participation made the participants consider themselves to have become lazy since they had to concentrate their energy on performing their necessary daily activities, instead of using it for participation in occupations that they considered to be more worthwhile.

Environmental pressure towards withdrawing from participation

Considered together, the encounters between the participants and their environment seemed to result
in environmental pressure to concentrate on performing the most necessary daily activities rather than to engage in participation. The encounter with individual and societal environments seemed to bring about a feeling of having to be content with life as it was, and a wish to ensure that they are not a burden on their families. Consequently, the participants felt compelled to concentrate on ensuring that they could accomplish the most necessary daily tasks rather than requesting assistance to enable them to maintain their participation. Moreover, the encounter with assistance from the healthcare system brought about the same kind of pressure, as the assistance the participants received meant that they had to prioritize the performance of primary daily activities rather than, for example, being able to engage in occupations that implied participation. Although the assistance received from the family was felt to promote participation, the participants’ wish not to be a burden made them feel compelled to ensure that they could accomplish the maximum number of primary tasks possible. Furthermore, owing to the combination of many seemingly small environmental hindrances, the unreliability of the ageing body and the occupations that they did engage in together became increasingly exhausting processes in daily life. Consequently, concentrating on the most necessary daily tasks demanded much of the participants’ energy and, taken in conjunction with the environmental pressure, indirectly forced them to reduce their participation in, for example, social and leisure activities.

Discussion

The discussion falls into four themes, each of which is discussed separately below. The discussions are held under self-explanatory headings: different pressures from individual and societal environments, contentment in spite of the reduced possibilities for participation, the process of all of the small things adding up, and, finally, the gap between policy and practice.

Differences in the pressures from individual and societal environments

One of the main findings was that the pressure from individual and societal environments differed. Individual environments where people interact face to face, such as family, healthcare professionals, and attitudes of others seemed to stimulate participation in our study. The participants even felt that the attitudes of the people they met had become more positive in recent years. This is in contrast to the experiences of young disabled people (11,12). This can be understood partly in terms of the attitudes of the individuals participating in the investigations because when elderly people receive personal assistance, they perceive it as someone having a “nice attitude towards elderly people”, such as when one of the male participants was impressed by railway staff who carried him into and out of the train as well as within it. In comparison, young disabled people claim that transportation should be accessible to everybody, and they refuse to be dependent on receiving personal assistance (12). Another difference between young people with a disability and the participants in this study was that physical environments were not the main barrier to participation; instead their participation limitations were associated with having somebody to accompany them or to visit. This difference between the experiences of young and old people with disabilities in what they experience as a “nice attitude” and the influence of physical environments should be explored further.

Interestingly, the positive attitudes that the participants experienced from the individual environment were in contrast to their experience of the societal environment, where the attitudes of politicians and the media gave them the feeling of being an item of expenditure only. In their opinion, the most apparent societal barrier was the system of healthcare services because interacting with the healthcare system occupied so much of their time and exhausted them. Moreover, the contact with the healthcare system often implied that the participants were deprived of control over and the ability to participate in decision-making in matters central to their daily lives, which is an important aspect of participation (20). This finding is in accordance with other studies and theories that point out that the healthcare system is perceived to be a hindrance to the participation of people with a disability (29,37).

This finding indicates two dilemmas for occupational therapists in geriatric community rehabilitation. First, occupational therapists tend to concentrate both their practice and research on the clients’ ability to perform ADL activities within the home (10,38). Through this choice, therapists could contribute to the pressure on individuals to perform ADL activities and thereby hinder participation since they explicitly pass on their values to the clients. Furthermore, occupational therapists seem to concentrate mainly on the physical environment while ignoring societal aspects of the environment (39,40). Consequently, our results suggest that therapists and rehabilitation professionals need to better understand the interplay with both individual and societal environmental factors and recognize how these influence their clients’ lives.
Second, occupational therapists need to recognize that they are part of the societal environment, referred to as the healthcare system or services, that could be experienced as a hindrance to participation because of the demands it imposes on people’s time. For example, occupational therapists are often responsible for the delivery of assistive devices in Scandinavia (41–43). Even though the participants in this study were impressed by the therapists’ competence where assistive devices were concerned, other studies have shown that people have had the experience that therapists hinder their access to assistive devices (43). Since OTs in the community often have a “gate-keeper role” regarding assistive devices, it is necessary to be aware that this role can serve as an obstacle and restrict the clients’ possibilities to maintain control and to participate in the decision-making issues central to their own lives (41,43).

Contentment in spite of the reduced opportunity to participate

In spite of the fact that our participants had to give up important occupations, they were content with their lives. This could be understood from their claim to have had their share of life, just as Nilsson (44) found that people who had lived active lives were content with their life in old age. In our study, social support and being part of the family were important for the participants, all of whom had contact with relatives. The provision of social support could be a contributory factor to their contentment, since this is known to be a primary condition for the well-being and participation of elderly people (25,27). However, being content also seems to relate to our participants’ wish not to be a burden on their relatives or on society, as has also been found by Lysack & Seiphe (45). Their wish can be understood in light of the apparent attitude of politicians and the media in regarding elderly people as expensive and useless members of society. Moreover, in Western society, the ideal is self-care and independence. The strong emphasis our participants put on being satisfied if they could manage their own self-care indicates that elderly people do not make claims for themselves (28). One implication for rehabilitation services is to make sure that the clients’ contentment with performing ADL does not stem from their wish not to be a burden. Additionally, the finding of the importance of social environments, such as support and help from family and friends to ensure that participation continues, should be taken into consideration in rehabilitation plans, in addition to ensuring that environments are accessible in people’s homes. Finally, if it is the case that elderly people in our society perceive that they are not allowed to complain, healthcare professionals must take the responsibility of informing society about the environmental barrier to participation.

The process of all the small things adding up to create pressure to perform primary daily activities

Our results indicate that, after an acute illness or accident, elderly people may be increasingly sensitive to minor changes in, for example, bodily function, daily routines, and environmental and occupational demands because these seem to compound to make a burdensome process in daily life. This is a complex process that seems to contain a number of explicit and implicit factors. According to our findings, no single factor can be identified as the main barrier; rather, the barriers comprise “all the small things adding up together”, including occupations themselves. Traditionally, the person–environment theories (17,19,37) focus on the interaction between the individual and the environment. Similarly, from an occupational therapy perspective, theoretical models that seek to clarify the interactions between the individual, environments, and occupations (13,15,16) seem to be the most useful in order to fully understand why elderly people do not continue to participate as they had done before an illness or accident. OT and rehabilitation professionals have a serious challenge to understand how together to combat the combination of these small things to help the client to handle the pressure to concentrate on primary ADL instead of participation. Since much research on and assessment of environmental factors often concentrates on just a few factors at a time (46), there is a need for more research to be conducted on what kind of environmental factors elderly people with reduced functional ability perceive as facilitating or hindering participation.

A gap between policy and practice?

As our results show, elderly people seem to experience considerable pressure to concentrate on primary daily activities even though Norwegian rehabilitation policy (5) and the ideology and theory of rehabilitation and occupational therapy explicitly state the importance of assisting people to participate in society and of removing barriers to stimulate such participation (2). This finding indicates that there could be a gap between the individual experiences of the clients and the policy and practice of OT and rehabilitation in the community, as well as between national policy and the local execution of this policy. While central authorities develop idealized policies, the local authorities must make
decisions compatible with their budget, when, for example, organizing rehabilitation services. These policies and decisions can influence the daily life of each client, as well as the way healthcare professionals provide their services. Not surprisingly, many healthcare professionals experience a conflict between the policy guidelines and their capacity to provide their clients with beneficial services as health professionals (47). The study just referred to showed that municipality healthcare staff felt that they were unable to fulfill the expectations of the central healthcare philosophy and ideal policy.

In conclusion, if the goal of participation for elderly people who receive rehabilitation after an acute illness or accident is to be attained, far more attention needs to be given to the facilitation of participation from individual social environments, such as receiving support from family and friends. Additionally, awareness needs to be increased of the possibility that societal environments may be perceived by elderly people as pressure to concentrate on ADL. And far more attention must be given to the fact that the healthcare system itself may be a barrier to participation. Facilitating elderly people’s occupational engagement and participation in society is not just an ideological issue for OT and rehabilitation theory: it is one with implications for the health and welfare budget since participation positively influences the health and well-being of elderly people (2).

Methodological considerations

The experiences of our participants are related to the Scandinavian welfare system and, more specifically, come from Norway, but our findings concerning the importance of societal environments are similar to those of studies conducted in the UK and Canada (37,48) in terms of support of the family and the healthcare system. While the findings from this qualitative study cannot be generalized to other populations, we assume that certain aspects such as the importance of social support and the experience of healthcare are likely to appear among other elderly people who have a disability system in a similar society.

In this study, focus-group methodology was considered to be a relevant method because the interview format inspired the participants to discuss and compare their experiences of the environment in which they live (33). They had different experiences but it turned out that they shared common perceptions of the environmental influence. Since the moderator promoted interactions among the participants and encouraged them to talk to each other, all group members engaged in the discussions. Consequently, our data reflected both shared and divergent experiences, meanings, and attitudes of the participants and the groups, which was considered an advantage given our aim. Nevertheless, while our participants verified the importance of discussing matters such as these, they also pointed out the risk of other important issues of a more private nature being left aside. On the other hand, the participants said they felt confident with the group, the moderator, and the assistant and added that they were not reluctant to express their opinions. The design of each group meeting several times facilitated the discussion, as the interaction in the groups increased with time. Additionally, the participants seemed to be more open with critical comments concerning their environment in the third and fourth group setting. Therefore, we have reason to believe that the group sessions provided insight into the participants’ perceived experience of the environments concerned.

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References

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