Research Article

Personal Life Approach: An Interactive Way of Understanding Older Adults’ Participation in Activities Following Hospitalization

Elizabeth Pritchard, MHScOT,1,* Narelle Warren, PhD,2 Anna Barker, PhD,3 Ted Brown, PhD,4 and Terry Haines, PhD1,5

1Department of Physiotherapy, Monash University, Peninsula Campus, McMahons Road, Frankston, Melbourne, Victoria, Australia. 2Social science and health research, School of Psychology and Psychiatry, Monash University, Clayton Campus, Wellington Road, Melbourne, Victoria, Australia. 3Department of Epidemiology and Preventive Medicine, The Alfred Research Center, Monash University, 99 Commercial Road, Melbourne, Victoria, Australia. 4Occupational Therapy Department, Monash University, Peninsula Campus, McMahons Road, Frankston, Melbourne, Victoria, Australia. 5Allied Health Research Unit, Monash Health, Melbourne, Victoria, Australia.

*Address correspondence to Elizabeth Pritchard, MHScOT, Department of Physiotherapy, Monash University, Peninsula Campus, McMahons Road, Frankston, Melbourne, Victoria 3199, Australia. E-mail: elizabeth.pritchard@monash.edu

Received April 17, 2014; Accepted October 20, 2014

Decision Editor: Barbara Bowers, PhD

Abstract

Purpose: To explore factors that support or inhibit participation in daily activities amongst older adults who have returned home following hospitalization.

Design and Methods: An exploratory qualitative design was used to gather information from a sample of older adults. Participants were recruited during their hospital stay from acute and rehabilitation wards in Victoria, Australia. Semistructured interviews were carried out in the participants’ home within 6 weeks of discharge. Data were analyzed through thematic analysis.

Results: Participants (n = 21) were aged ≥65 years (mean 82 years [SD 8.5]), 57% were female (n = 11) and 76% with English as their first language (n = 16). Thematic analysis identified one primary theme (personal life approach) moderated by spirituality and two subthemes; interpretation of physical and mental abilities, and social interactions. The life approach acted as a filter through which participants interpreted their abilities and social interactions that either supported or inhibited their return to participation after a stay in hospital.

Implications: The findings suggest that clinicians need to consider the individual’s approach to life in their recovery following hospitalization. This approach can influence their return to participation in activities and potentially be supported (towards higher levels of optimism) by health professionals to enhance participation in activities postdischarge.

Keywords: Participation in activities, Hospitalization, Internal/external control, Optimism, Qualitative analysis: thematic analysis

Participation in life activities is an innate human need and a goal that health professionals work towards with clients (Townsend & Polatajko, 2007; Wilcock, 2005). Various definitions of participation are presented in literature, although consensus has not yet been reached. The World Health Organization’s definition states involvement in life situations which encompasses physical capacity in a variety of contexts (World Health Organisation [WHO], 2002, p. 10). Participation referred in this article incorporates a broader approach to activities including physical (function) and psychosocial aspects of thoughts, volition (thinking process to elicit action), and social connectedness influenced...
Determinants of participation are wide ranging and include physical health, function (Chalé-Rush et al., 2010), mental health and psychological status (Pierluissi et al., 2012; Pritchard, Barker, et al., 2014), social relationships (Levasseur, Desrosiers, & Tribble, 2008), and environmental considerations (Rosenberg, Huang, Simonovich, & Belza, 2013). Social connectedness and relationships can be seen as both a determinant and an outcome of participation. Participation in activities has been reported as complex, individually defined, and pursued according to people’s values and beliefs in personally meaningful roles (Hammel et al., 2008). High levels of participation in specific activities by older adults has been associated with higher levels of life satisfaction and lower levels of depression (Gautam, Saito, & Kai, 2007); longstanding activity engagement have been associated with higher life satisfaction and successful aging (Stevens-Ratchford, 2011). Greater satisfaction with participation in social roles with fewer environmental barriers has also been identified as predictors of increased health and well-being (Levasseur et al., 2008). Although these studies shed light on the determinants and benefits of participation, this has not been extensively investigated with older adults following hospitalization (Pritchard, Brown, Barker, & Haines, 2014) and is therefore important to consider for successful health outcomes.

Participation is influenced by the concept of volition, which refers to a person’s ability to plan, maintain, and implement intentions, which in turn leads to action (Broonen, Marty, Legout, Cedraschi, & Henrotin, 2011; Kielhofner, 2008; Pritchard, Brown, et al., 2014). Higher levels of volition have been associated with higher levels of participation in a selection of household and recreation activities amongst older adults (Pritchard, Brown, et al., 2014). Volition requires that the chosen activity has a degree of personal meaning; that individuals understand that they can achieve the activity (e.g. self-efficacy); and that they have interest in performing the activity (Forhan & Backman, 2010; Kielhofner, 2008).

A stay in hospital can cause significant disruption to participation in roles and routines (known as occupational disruption) (Kortebein, 2009; Townsend & Polatajko, 2007). This transient disruption can cause a decline in physical and/or cognitive function which can lead to deconditioning, identified in one-third of hospitalized patients (≥70 years) (Courtney et al., 2012; Kortebein, 2009). Decline in physical or mental health has been reported to negatively impact participation in daily activities and quality of life (Courtney et al., 2012). This is associated with increased depressive symptoms (Pritchard, Barker, et al., 2014), and can lead to falls and fear of falling (Hill, Womer, Russell, Blackberry, & McGann, 2010), as well as increased hospitalization and mortality (Courtney et al., 2012). Low levels of participation that eventuate in a hospital admission can perpetuate a detrimental cycle of deteriorating health, contributing to chronic health problems and the increasing burden of disease (Courtney et al., 2012).

Previous studies have investigated participation in older adults in acute hospital (Eyres & Unsworth, 2005); immigrant populations (Suto, 2013); or people with a specific diagnosis (e.g. motor-neuron disease) (Brott, Hocking, & Paddy, 2007). However, little is known of the factors that mediate or potentially mitigate the effects of decreased participation postdischarge; despite evidence that health decline is problematic for older adults following hospitalization. This presents a clear need to gain greater understanding of these factors.

The aim of this study was to address the research gap by exploring factors (enablers and barriers) that support or inhibit returning to participation in activities posthospitalization from the participant’s perspective. This will provide valuable insights into the mechanism by which rehabilitation interventions can be optimized to improve participation and health outcomes amongst older adults.

Methods
Design
This manuscript presents an exploratory qualitative study investigating posthospital participation amongst participants recruited from acute and rehabilitation hospital settings.

Procedure
A quota sample of older adults residing in hospital (≥48 hours) was recruited prior to their return home. The intended sample was approximately equal numbers of male/female, across settings (acute/rehabilitation), and with a spread of age groups. Occupational therapists and nurse managers approached potential participants who met the inclusion criteria of ≥65 years, currently staying in hospital with a documented discharge plan to home, able to understand/converse in spoken English, without significant cognitive impairment (determined by the treating team), and ability to give written consent to participate in the study. The first author visited the individuals in hospital to explain the study before participant agreement was sought. Demographics were collected after consent was obtained regarding age, gender, ethnicity, length of stay, rate of falls prior to/since hospital (number of falls divided by 365 days/ number of days since discharge), and living situation. These variables were selected as they have been previously reported as important moderators of participation amongst older adults (Chalé-Rush et al., 2010; Pritchard, Barker, et al., 2014). Participants were then visited at home within 6 weeks of discharge for interviews.

The 1-hr semistructured interview incorporated discussion regarding current and past participation in activities, and identification regarding enablers of and barriers to returning to participation. Each interview commenced by asking participants “Can you tell me about the activities you do in a day?” followed-up with “has this changed since hospital in any way?” and “what assists/stops you from returning to these activities?” Interviews were audio-recorded and transcribed verbatim.
Participants reported their participation levels and individual volition scores during quantitative data collection (not reported here). These scores were subject to a range of influences that were not well-captured by quantifiable questionnaires or scales. Qualitative data, gathered through face-to-face interviews, were analyzed through thematic analysis.

Ethical approval was gained through Monash Health and Monash University Human Research Ethics Committees (CF12/3220-2012001609).

Participant Characteristics
During recruitment, 39 people were screened with 24 participants enrolled. Two participants withdrew due to ill-health, one died prior to interview, and 21 completed the interviews. The mean age was 82 years (SD 8.5), range 68–95, and 11 were female (57%) with over half of the participants Australian born (62%). Eleven participants (52%) were recruited from acute hospital settings, with the remainder from rehabilitation wards. English was a second language for five participants (25%), but no interpreters were required. Presenting health conditions reflected a typical range for older adults of cardiac (29%); falls (20%); stroke (14%); respiratory (14%); and other (24%) (WHO, 2002). All participants reported longstanding health issues with two or more comorbidities, which variably impacted on their participation levels.

Analysis
Inductive thematic analysis (Braun & Clarke, 2013) of the transcripts was carried out following the completion of data collection. The six-step process incorporated: familiarization with the data, whereby the researchers read and reread the interview transcripts (step 1); generating the initial codes evident in each individual transcript, in which key words, phrases, and conceptual ideas were identified (step 2); searching for themes occurred where the researchers actively sought to reduce the codes generated in step 2 by looking for patterned responses that “cut across” the data set (step 3). These “themes” were salient for multiple participants and thus became the basis of the analysis reported here. Themes were considered to occur when they were described by three or more participants. In step 4, themes were reviewed and the extracts coded under each one were considered in relation to their “fit” within that particular theme. Simultaneously, the relevance of each theme in responding to the research question was considered. The researchers then compared and discussed the developing themes. If there was disagreement regarding the themes, the conceptual basis of each (i.e. what each theme was seeking to capture) was discussed and redefined until consensus was gained. Step 5 involved defining and naming themes, and a thematic mind map was produced to aid in this task; and for step 6, a report was produced (Braun & Clarke, 2013). Quotes from the transcripts were reported to support the themes using pseudonyms and age (years) depicted in parenthesis. NVivo (QSR International, 2010) was used for data management of the transcripts and for coding of the text into key words and phrases.

Methodological rigor of the qualitative analysis was ensured in three ways. First, a process of member checking occurred, where two participants reviewed the researchers’ interpretation of their data to evaluate if the meanings of their experiences were appropriately captured. Selected excerpts from their personal transcript with the identified themes highlighted were discussed, as was the proposed final model (Creswell, 2003). Both participants agreed with all aspects of the interpretation of their narratives and the themes identified in the final model. Second, a coding check of two transcripts (70–80 sentences) was completed by a colleague external to the project to determine the fit and relevance of the author’s coding structure. The average kappa coefficient for inter-rater agreement resulted in .73 and .75 (transcript one and two respectively), which was indicative of high levels of agreement (QSR International, 2010). Third, the concept of diminishing returns, where additional interviews do not add any further themes to the analysis, was used to reflect on the appropriateness of the study sample (Creswell, 2003). No new themes emerged in the analysis after 14 interviews, suggesting that the sample size of 21 was sufficient.

Results
Participants’ personal life approaches (PLA) were a key factor in determining their level of participation in activities following hospitalization. Although it incorporated personal values (Hammel et al., 2008), the PLA extended beyond a focus on social roles to encompass affective (feeling) dimensions. It incorporated the way participants viewed life, particularly their response to challenging life events, and thus drew upon the psychological concept of valence (Windsor, Burns, & Byles, 2013). In doing so, one’s PLA was determined by their work ethic, the coping strategies they employed (including attitudes, beliefs, and their approach to problem-solving), their optimistic versus pessimistic view of circumstances, their acceptance of the situation and current abilities or limitations, their level of volition, the way in which they reframed expectations (positive or negative), and their experience of spirituality. The PLA acted as a filter that determined how the subthemes—physical and mental abilities (subtheme 1), and social interactions available (subtheme 2)—supported or inhibited participation (see Figure 1). These subthemes also interacted with each other through the physical and mental abilities limiting social interactions or driving the need to find increased interactions due to this level.

Participants’ life approaches integrated an attitude of self, others, and events which was positioned on a continuum of optimism (of the future or their abilities) to pessimism. This related to how previous experiences, work ethic, personal attitudes, and beliefs shaped future perceptions that enabled return to participation in activities. For some, role-modeling from significant people reinforced their innate determination to find a way through adversity:
I think I got [my strong will] from my father… He was a hardworking man, very strong willed. I’m the same probably.

Like Janet, others described how the “hard work” ethic and approach to life made them willing to address any barriers or challenges to participation that they faced in recovering after hospitalization. Maria (70), for example, was raised by her grandmother and adopted her perseverance; this assisted Maria’s return to wellness following significant adult health issues: “She just … took everything that came along … We’ll embrace it and we’ll deal with it.”

For Maria, this approach influenced her active engagement in home and community activities; rather than a fatalistic acceptance of the physical decline that followed her hospitalization following “a collapse,” she displayed determination to return to her participation gradually. Where participants’ PLA was positively geared and optimistic, participation in life activities was enhanced, as Janet and Maria exemplified. This optimism was linked with determination to work hard at the process of recovery and overcome practical and personal challenges:

[I] think it’s got to be in your mind, that you want to do it ... I’ve known people in their 50s and they’ll pack it in ...

(Helen, 94)

Helen’s ethos regarding the importance of working hard shaped her recovery following hospitalization for breathing difficulties, even though she experienced daily pain and stiffness due to arthritis. At the same time, she readjusted her expectations and priorities regarding recovery:

[I was very tired [after discharge from hospital] ... But after a few days I came good. I consider that if I want to keep going I must keep exercising and using what I’ve got. If I don’t use it I’ll lose it.

Refining Expectations of Recovery

At the same time, participants who reported working hard to achieve higher levels of participation typically engaged coping strategies that included reframing of thoughts and expectations.

[If] I have a limitation, I stop and accept. I am happy with that particular achievement. It is not perfect but it’s near enough.

(Ivan, 75)

Similarly, other participants described how they readjusted their roles to accommodate a more graduated understanding of the recovery process. In doing so, they highlighted the two central components of this new understanding of recovery: the identification of challenges as they arose was central to this, and allowed these participants to devise a solution which led them to a successful return to participation. This occurred with various activities in the home and community, as Christina (85) explained:

I put a lot more dirty dishes and things in the dishwasher ... Little piffling things I do ... I shortcut a bit sometimes with cooking ... I might buy a few things that I didn’t use to buy.

Such problem-solving was about effecting small adaptations to make their everyday life easier. This required an acceptance of the situation which was germane to participation and staying positive as Irena (89) described: “I think positive, I don’t worry. I don’t think ahead what’s going to happen because that doesn’t help.”

The Impediments of A Pessimistic Personal Life Approach

In contrast, participants who displayed a more pessimistically biased PLA reported impediments in returning to activities or in adapting their lives in ways to facilitate this return. Fatalism, an understanding that nothing they could do would change their health outcome or their ability to meaningfully participate in life following hospitalization, was significant here: these participants were preoccupied with their physical ill-health, did not voice determination,
or use a problem-solving approach to overcome anticipated obstacles. For example, despite encouragement from others, Epsa (68) felt she was unable to be socially active any more:

I … feel tired [all the time]. My sister gave a [phone-call] yesterday, [and said] come for coffee. Oh no I am tired no, never go. One lady [rang], saying come to my party. No, I can’t. Never do.

Low levels of participation for Epsa (68) were negatively shaped by her pain, tiredness, and unwillingness to leave home following hospitalization for “heart problems.” Similarly, Christos’ (71) preoccupation with physical limitations pervaded his life and eliminated possibilities of achieving participation. In discussing his participation, Christos, like Epsa, presented a scenario of helplessness:

You don’t think yourself [as able to do things] … You say why this should happen to me, why? … What choice do I have? I can’t do anything. I can’t occupy myself or anything, I can’t.

Christos’ refrain of “I can’t” was repeated throughout his interview and highlighted the significant mental barrier to participation experienced by some participants. He struggled with accepting the traumatic life changes as he recovered from medical misadventure which left him unable to walk or drive. Christos’ refusal to accept his circumstances prevented him from adapting his approach to enable participation.

Participants’ pessimism was not only reflective of their level of acceptance, but was also shaped by their difficulties in adjusting to limitations imposed by their poor health. This was the case for Patricia (86), who struggled with adapting to the restrictions imposed by her recent diagnosis of blindness: not only was her participation impacted but so too was her enjoyment of previously valued activities. She found it difficult to accept the deterioration in her abilities and lamented her loss of sporting and social activities to the point of feeling burdensome to her family as well as society:

I can understand euthanasia … I feel I am a burden. I am a burden on the government … on my son and to a degree … on [my partner].

Achieving Independence

The lack of acceptance or ability to overcome the physical limitations was a barrier to participation for some individuals in this study, as described above. However, this was not the case for everyone. Several individuals employed adaptive strategies to continue achieving the activities that were meaningful to them in spite of their physical limitations. For example, despite requiring extensive medical treatment for three days each week, Christina employed a type of trading off to accomplish what she could. She selectively relied on others to undertake more mundane tasks or activities, such as cleaning, so that she could continue taking part in activities that were most meaningful for her, such as going to a café. Her optimistic PLA was significant in this process, as it facilitated her reframing ideas of independence to accommodate a degree of interdependence, thus eliminating the sense of burden described by participants with a more pessimistic PLA.

Such strategies provided participants with the impetus (understood in terms of motivation) to take part in meaningful activities and translate intention into action (known as volition):

I’ve got to drive myself a bit. I mean I can sit and feel sorry for myself or I can get up and go. So I think I’ve got to help myself.

(Muriel, 85)

Significantly, for these participants, their desire to remain independent both influenced and contributed to their PLA:

I want to go on living! If I’m going to be here I don’t want to be miserable. I want to be bright and able to do, and look after myself… If they take my independence I’d be gone… I’ve always been independent.

(Helen)

Because of my nature, my inner thing, I like to achieve things… [Achievement] drives me all the time… I have limitations, I recognize those limitations and I am trying to overcome them all the time.

(Ivan)

By focusing on their goals, these participants were able to adapt to limitations and develop new ways to overcome obstacles in order to maximize their independent participation. This often required hard work, on both mental and physical levels, as Maria explained:

I used to be highly motivated and a workaholic before [the accident] … [It’s hard work] physically and mentally trying to stay on top of things … I think I’ve always been very self-sufficient and independent … that is probably one of [the] things that motivate me. A strong desire not to lose that.

Thus, through translating their PLA into action, they sought a sense of well-being.

Spirituality and PLA

Well-being also came through spirituality or the search for something sacred and deeply meaningful which strengthened PLA by mediating participants’ strength to cope. This incorporated varied routines from meditation, to specific religious practices and beliefs e.g. praying. Participants’ religious beliefs brought strength and calmness in response to their current situation and was illustrated by Helen, who saw each day as a blessing: “The first thing I do every morning, I thank God for another day.” Participants whose
PLA was characterized by optimism sought more diverse ways to experience calmness and show gratitude that led to a greater appreciation of being alive:

I really find that I stay focused [when meditating] ... I feel good ... I’m thankful to be here... I’m obviously here for a reason and I think ... you give the best you can and enjoy life. That’s what it’s all about. You are here for just a short time anyway.

(Maria)

Experiences of spirituality were intertwined with the PLA and aided day-to-day coping through giving meaning and purpose to life, religious practices, and the desire to continue living. Participants’ responses to their current circumstances were driven by internal drivers of optimism, determination, and spirituality that supported participation or by helplessness, pessimism, and fatalism, which sabotaged participation by constructing decline as inevitable.

Interpreting Physical and Mental Health (Subtheme 1)

PLA was influential in how participants interpreted their physical and mental health status and shaped how, regardless of their functional capacity, some felt they could overcome barriers—present or future—while others did not. Barriers to participation included loss of confidence and fear of falling, low levels of volition, pain, and negative emotions. Restricted physical abilities were a palpable regulator of participation for some, which was associated with loss of confidence: “Because of my physical injuries ... I did lose my confidence short-term” (Mary, 72). Two levels of response resulted from this loss of confidence, which were shaped to some extent by PLA: participants either took responsibility for identifying alternative methods to address the lack of confidence or they allowed the experience to become a barrier to future attempts of participating. Fatalism and pessimism impacted on confidence in much the same way as they influenced other aspects of participation. This was clearly evident in a psychological factor related to loss of confidence: a fear of falling that stemmed from a traumatic fall experience, which was identified by over half of the participants. Participants’ responses to this fear—influenced by their approach to moving within the environment and reflective of their PLA—profundely shaped their participation. Four participants described adopting a cautionary approach to how they executed tasks which acted as a protective factor against potential injury: “I don’t want to fall ... I don’t want to have to go back to hospital. I’m careful what I do. I think twice before I do anything” (Janet). However, others identified that they were too scared to even attempt the activity: “I can’t go out ‘cause I worry I will fall again” (Anh, 80). This was attributed to the lack of confidence they felt to perform the activity safely rather than challenges of the physical environment and highlighted one way in which pessimism was manifest.

Participants did not identify that the physical environment (e.g. steps, surfaces or equipment) was a deterrent to participation; however, the weather (if windy) was identified as one, on several occasions due to the difficulty to breathe. Most participants did not consider the environment as either a deterrent to or an enhancer of participation, but rather an expected component that was present, as described by Ivan: “You take environment as it is.”

The Demotivating Effects of Pain and Fatigue

Volition was negatively influenced for some by physical restriction, fatigue, and pain. The varying levels of fatigue and lack of energy that accompanied a hospital stay slowed many down after discharge, particularly those who had a more pessimistic outlook: “Oh tired, very very tired ... I come back and can’t do it even then” (Epsa).

This is not to say that fatigue was not an issue for more positive participants; rather they were able to pace themselves and apply an optimistic response to these factors despite the impact. Christina further described the effects of hospitalization on energy levels and the struggle to respond to this:

I find that I am almost totally uninclined to do anything [after hospital]. I don’t have any zip, any get up, and go or anything ... The thing that is amazing is how QUICKLY you go down and then [its] not so easy to get back again to a certain level.

Physical pain was mentioned by over half of the participants, with varied responses. Janet’s pain majorly disrupted her participation, whereas Helen explained that pain motivated her to increase her activity levels in order to deal with feeling sore. Maria increased participation when recovering from a car accident despite pain to gain a greater feeling of control and independence:

I’m asking [family and carers] to do less and less now, so that’s good. I’m happy to be doing that. I’ve got more control of my life back again, something I’d lost for a long time.

Such perceived control was strongly linked to emotions: a number of participants described needing to feel “in control” before participation could be actualized. Experiences of negative emotions (sadness or feeling downhearted) interfered with this. However responses to negative emotions varied in interpretation, from a short-term interruption to a long-term outlook of inability to achieve anything: “I never feel peaceful ... I have no energy. I am just weak and upset, that’s all” (Christos).

There was a sadness pervading many participants’ accounts, who sought to balance their ongoing disappointment of not being able to complete desired activities with the need to adjust personal expectations. However, most people found the best way of handling this was through acceptance:
I accept things. I don't like it sometimes but I accept it... I get cross with myself but... I won't allow myself [to get down]. I am strong willed.

(Janet)

Factors of fear of falling, low volition, pain, and negative emotions were demotivating to a return to participation. However, determination to overcome these physical limitations and the quest for independence were evidence of enablers of participation through a successful positive and inner strengths approach, which was also influenced by interactions with others.

Social Interactions and Support (Subtheme 2)

Experience of positive social interactions and support were important factors that predominantly maintained or enhanced participation and promoted social connectedness. The need for social interaction, especially when connections were limited or nonexistent, propelled several people to access the community or shopping centers to stave off loneliness. PLA shaped participants’ willingness to engage in (or not) social interactions including the nature and type of support that they sought. Those with more pessimistic PLA tended to withdraw or isolate themselves from social interactions. Despite having a supportive social network who provided multiple invitations for participation, Epsa never accepted these invitations, preferring to stay home. Her PLA was central to, and shaped her understanding of life after hospitalization. In contrast, Maria found that social interaction, provided by her neighbors or the local shops, was a catalyst for staying positive: “A bit of human contact [is good] that way they can bring you out of yourself and stop you feeling sorry for what’s going on around you.” Her outwardly focused approach to life meant that she was willing to interact with others in trying to achieve participation regardless of her functional status.

In contrast, other participants identified impediments on participation when close family members or friends imposed restrictions:

[The daughters] were terribly worried about me going on public transport. I thought I might have been able to but ... they didn't like me to do it... They would like to take me [to the shops] but they don't always have time, and I just have to forgo.

(Christina)

Several participants took note of their family/friend’s concerns and curbed their activities, whilst others refused and continued with their intentions. Their PLA influenced how they interpreted the comments and balanced the need for acceptance or approval versus their determination (and ability) to complete the activities, as Maria described:

[Family] think I overdo things... ‘Don’t go there mum, don’t do that’ ... I find [it] a bit hard at times ... When I attempt something it’s almost like I am going to be criticized and I have to explain why I have done it. They don’t seem to understand that... I still need to take risks to keep myself going.

Interactions with health professionals also encouraged participation, as Mavis (82), who was severely physically restricted following multiple episodes of ill-health, explained: “[They helped through] encouragement and being positive. The nurse [has] ... really become quite a good friend.” However, three people identified that the health professional’s recommendations prevented any attempt to return to specific activities until permission was granted (e.g. shopping).

The presence (or lack) of support was identified as being both an enabler and an inhibitor of participation depending on the personal circumstances and interactions that each individual experienced. However, people with more supportive networks tended to return to participation more rapidly.

Discussion

The ways in which individuals returned to participation following hospitalization involved complex responses to adverse situations. This was influenced by modeling of significant people and behaviors learned from previous life experiences. Many participants in this study sought to normalize their health experience through minimizing the effects of the health disruption in order to “reconstruct” their self-identity (Faircloth, Boylstein, Rittman, Young, & Gubrium, 2004). Participation in chosen activities can be supported or inhibited through this adaptation, thus maintaining continuity over time and space. Ability to manage disruption to participation was determined through the participant’s personal life approach (PLA). Those with a more optimistic PLA approached the barriers and enablers to returning to participation pro-actively and even at times, take risks. Conversely, those with a more pessimistic PLA tended to get “stuck” in the limitations and barriers of the situation. The degree of effective use of coping strategies and flexible problem-solving was observed to be based on past skills and learning. Coping was strengthened through spiritual practices which align with previous research regarding self-management of chronic disease (Unantenne, Warren, Canaway, & Manderson, 2013). The presence of these adaptive coping skills allowed individuals to reshape their experiences, acting as an enabler by overcoming significant barriers which supports previous research findings (Romo et al., 2013). Conversely, the lack of these skills inhibited participation for a selection of participants.

Barriers to participation were also surmounted through the power of optimism. Optimism incorporates a positive and realistic understanding of one’s abilities whilst dwelling on the hopeful aspects of a situation (Bowling & Iliffe, 2011). Researchers have also reported that optimism is
associated with higher levels of health and well-being and can be increased (Forgaard & Seligman, 2012). Being optimistic is an evidenced coping strategy that strengthens health/well-being including positive reframing of thinking, determination and maximizing the psychological resources of self-efficacy, and builds resilience to bounce back from adversity (Bowling & Iliffe, 2011; Ferreira & Sherman, 2007). These strategies were exhibited by participants (with a more optimistic PLA) and were linked to the individual meaning and value of the activity. This contributed to strengthening volition to elicit participation. It was also noted that participants from an immigrant background presented lower levels of optimism and determination, thus reducing their participation, although this was not fully explored.

The extent to which participants took responsibility for their progress, accepted their limitations, created ways to reframe their thinking, and solved practical problems reflects the theory of locus-of-control (Rotter, 1966). This relates to the degree an individual believes they are responsible for their own health (Stewart, Chipperfield, Perry, & Weiner, 2012). Locus-of-control consists of internal drivers (the ability and effort of the individual) or external drivers (events being attributed to chance or luck) and can be identified on a continuum (Stewart et al., 2012). The participants in this study who were driven predominantly by internal drivers (determination, adaptation) experienced higher participation levels than those driven by external factors (other's expectations, diagnosis), which demonstrates these principles.

Researchers suggest that older adults with an internal locus-of-control are less likely to experience deleterious effects of chronic strain which can contribute to ongoing health issues and hospitalizations (Krause, 1987). A multi-site longitudinal randomized control trial with older adults in the United States examining the effect of cognitive training on the development of locus-of-control reported improvements with reasoning and speed of processing (Wolinsky et al., 2010). These findings suggest there is an opportunity for health professionals to influence the development of locus-of-control, with potentially positive health outcomes.

The significance of volition was also considered within this study as a vital psychological factor that impacted participation (Kielhofner, 2008). The participants identified the importance of self-belief that they could perform a chosen activity, the personal meaning of the activity to be carried out, and the degree of interest it was to complete it were vital drivers for participation. This suggests that volition may need to be considered in health programs when focusing on returning to previous levels of participation posthospitalization.

Remarkably, environment was not a critical influence on participation and contrasts previous research (Rosenberg et al., 2013). This may be due to the participation emphasis on internal strategies and coping with day-to-day actions rather than external factors in the interviews. In the current study, environment acted more as a consideration after people had chosen the activity and not a determining factor prior to this. Participants developed ways to master the environment through adaptability, choosing a different route, choosing alternative methods, or adjusting priorities by leaving the activity for someone else.

Application for Clinicians

This study suggests that the personal life approach holds paramount importance to overcoming physical and mental limitations and return to participation following hospitalization amongst older adults. Being cognizant of this, clinicians in hospital or community settings could address the thinking and coping strategies elucidated in this work. This could be done initially through discussion with the individual alongside current interventions, and by including discussions on optimism. These interventions resonate with current positive psychology evidence that affirm improvements in optimism, happiness, and well-being are possible (Boehm, Lyubomirsky, & Sheldon, 2011; Seligman, Steen, Park, & Peterson, 2005).

A longitudinal randomized control trial of adults in the United States investigating how expressions of optimism and gratitude promote well-being found that focusing on the future with optimism contributed to increased life satisfaction (Boehm et al., 2011). Furthermore, there is growing evidence that people can gain control of their thinking and personal situation (optimism, locus-of-control) by actively changing their responses to their circumstances (Sheldon & Lyubomirsky, 2009).

Clinicians can assist individuals to increase their level of optimism and well-being by utilizing the “three good things in life” (Seligman et al., 2005) discussion during sessions. Participants are encouraged to write down three great things that happened, along with what caused them, daily for 7 days. In a longitudinal randomized study of adults, participants who completed this exercise significantly increased happiness and decreased depressive symptoms at 6 months (Seligman et al., 2005).

Limitations

It is important to note from the analysis that one person’s barrier was at times an enabler for another. For each individual, the identified factors and levels of participation are multilayered and at times exclusive; however, common themes have been presented.

Previous research of factors pertaining to optimism and locus-of-control has predominantly been explored with younger adults. It is therefore difficult to generalize this information to older participant groups and highlights the need for further research.

Conclusion

Participation in daily activities and life situations following discharge from hospital is a complex challenge for
older adults. This entails a number of moderating factors that either support or inhibit re-engagement with previous activities. The qualitative study identified that the participant’s personal life approach was the primary moderating factor of participation in activities. This was projected on a continuum from an optimistic approach, to a more pessimistic and helpless approach. The participant’s life approach appeared to determine the strategies they selected for coping and what was incorporated into their everyday life. This filtered the way they perceived their physical and mental abilities and enlisted social interactions. Participants with an optimistic life approach utilized many strategies for adapting their attitudes, reframing their thinking, altering methods of doing things, and selecting a more internal locus-of-control response to adversity. A higher level of participation was displayed when a more positive approach was adopted despite the immediate physical or mental health challenges.

These findings highlight the importance for clinicians to identify the personal approach to older adults in rehabilitation programs and contribute to an outlook of optimism. Clinicians could support and enhance an optimistic life approach through discussion and the use of simple cognitive reasoning strategies. This would potentially assist with developing a more internally driven locus-of-control that reflects optimism and resilience leading to enhanced participation in activities.

Declaration of interest
Terry Haines is Director of Hospital Falls Prevention Solutions Pty Ltd. This company provides statistical consultancy services and education to hospital staff members on the prevention of falls in hospitals. He has provided expert witness testimony on the subject of prevention of falls in hospitals to Minter Ellison Law Firm. These interests are not directly related to the subject material of the present manuscript.

Conflict of Interest
The remaining authors declare no conflicts of interest.

Acknowledgments
Narelle Warren is supported by a National Health and Medical Research Council (NHMRC) Australian research training fellowship part-time (GNT0606783)
Anna Barker is funded by a Career Development Fellowship funded by the NHMRC Australia (1067236)
Terry Haines is supported by a Career Development Fellowship from the NHRMC Australia (1069738).

References

Downloaded from https://academic.oup.com/gerontologist/article-abstract/56/3/504/2605643 by guest on 07 April 2019