

Occupational Transaction after Stroke Constructed as Threat and Balance

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Older adults who have had a stroke may experience anxiety, depression and difficulties participating in meaningful occupations while also experiencing excitement, discovery and satisfaction in creating a new occupational balance. The aim of this qualitative study was to explore how older adults experienced the changes in their everyday occupations after a stroke. Five women and three men who had experienced a mild to moderate stroke participated in focus group discussions. Systematic text condensation was applied. The participants' experiences revealed how the stroke was perceived as an 'occupational threat' that produced feelings of social exclusion which were experienced as occupational exclusion, deprivation, marginalisation and imbalance. However, at the same time, the participants reconstructed occupational balance by performing occupations in new ways. The

participants' experiences provided insight into how they perceived their occupations as threatened after their stroke, while at the same time endeavoring to reconstruct occupational balance. These findings indicate that everyday life after stroke is a time of transaction where people are actively involved in creating control, occupational balance and being socially included.

Keywords: Older adults, Occupational threat, Occupational balance, Stroke, Participation, Focus groups

People's experiences after stroke vary considerably, but many older adults experience anxiety, depression and difficulty participating in meaningful personal and social occupations (McKevitt et al., 2011; Paul et al., 2005; Hackett, Yapa, Parag, & Anderson, 2005; Mayo, Wood-Dauphinee, Cote, Durcan, & Calton, 2002) despite good functional recovery (White, MacKenzie, Magin, & Pollack, 2008). Understanding the impact stroke has on occupation is important, given that stroke is a leading disability worldwide and even with stable incidence rate, the prevalence is expected to increase due to ageing of the population (Aziz et al., 2008). Additionally, despite evidence from a US cohort study of 7,740 people that indicated that approximately 80% of strokes are mild to moderate (Wolf, Baum, & Conner, 2009), almost half of stroke survivors report unmet needs including mobility, falls, fatigue and decreased emotional well-being for up to 5 years (McKevitt et al., 2011).

After a stroke, people's pattern of everyday occupations is often disrupted and new ways of doing things have to be created (Mayo et al., 2002; Wallenbert & Jonsson, 2005). People often experience this adjustment process as gradual, complex and prolonged (Kirkevold, 2002; Mayo et al., 2002; Rochette, Tribble, Desrosiers, Bravo, & Bourget, 2006). Experiences in daily occupations after stroke can be characterized as "waiting for the dilemma to resolve", either by adapting to and accepting the new situation or waiting for an improvement (Wallenbert & Jonsson, 2005, p. 220). The results of most of the studies in this field describe a transition from the initial fear, shock, and hopefulness to sadness provoked by the loss in functional abilities, with eventual acceptance of the residual disability. While such studies provide some insight into people's emotional response and experience after stroke, there is a further need to explore the complexities of the adjustment process (Kirkevold, 2002; Pound, Gompertz, & Ebrahim, 1999) and to understand what facilitates the changes and transformations of meanings post stroke (Rochette et al., 2006) to inform the development of services to meet their occupational needs (Kessler, Dubouloz, Urbanowski, & Egan, 2009).

From an occupational perspective, which is a specific way of looking at human doing (Njelesani, Tang, Jonsson, & Polatajko, 2012), engagement in occupation is linked to well-being and making one's life meaningful (Jackson, 1996; Wilcock, 2006). In this sense, occupation is understood to be a fundamental human need, and to encompass the everyday activities or tasks people do to occupy themselves such as looking after themselves, enjoying life and contributing to social participation (Townsend & Polatajko, 2007). Well-being, including social relationships, also has an impact on survival and quality of life during the life course (Holt-Lunstad, Smith, & Layton, 2010). Restrictions on participating in occupation are attributable to increased age as well as to the stroke itself, and are defined as a predictor of reduced social participation (Desrosiers et al., 2005; Desrosiers et al., 2006). Because occupation is not a cross-cultural phenomenon, it has to be understood in its particular cultural context (Darnell, 2002), . which shapes the manner of an individual's subjective experience and participation; the way skills, knowledge and capacities are deployed (Hocking, 2009). Thus the aim of this study was to explore how older adults living in a Western cultural context experience occupational changes in their everyday lives following a stroke.

The Western Society as Cultural Context

The perspective taken in this study is that there is a relationship between health and occupation, which underpins the importance of human participation in the occupations of daily life (Molineux, 2011), and that people's occupations influence their lifestyles, social relationships, well-being and participation in society (Christiansen & Townsend, 2011). It is also assumed that different societies and cultures have specific occupational norms and value different occupational capacities and meanings related to what people want to do, need to do and can do (Whiteford, 2011; Wilcock & Townsend, 2000). Cultural values are described as one of the occupational determinants that regulate what people do and how they are rewarded (Stadnyk, Townsend, & Wilcock, 2011). In this sense, culture is a complex system that is

continuously in flux where people create different meanings that are negotiated, contested, maintained and changed as they interact with others and the environment (Geertz, 1973; Thorsen, 2005). Kantartzis and Molineux (2011) asserted that many features of what is considered as the 'ideal' way of life in Western societies is reflected within the English language. In this context work, productive and goal oriented occupations are highly valued (Darnell, 2002).

The terms occupation, in an occupational science context, implies that meaningful occupation can contribute to the construction and expression of self-identity (Kantartzis & Molineux, 2011; Laliberte Rudman, 2002). Social constructions of what is 'normal' involves issues of power and domination and may contribute to the silencing and marginalization of those who do not conform (Kantartzis & Molineux, 2011). From this perspective, stroke may be interpreted as contributing to the inability to conform, and thus creating marginalization in a particular cultural context. As far as we know, occupational changes after stroke have not previously been explored from this perspective. Thus the standpoint of this study is that occupational changes after stroke are constructed, negotiated and reconstructed within a social, historical and cultural context. Accordingly, this paper is intended to stimulate further discussion of occupational scientists' need to understand occupation from multiple ontological standpoints, rather than the essentially individualistic standpoint that has characterized research to date (Hocking & Whiteford, 2012).

Method

The current study employed a qualitative design committed to an interpretive understanding of human experience (Denzin & Lincoln, 2005) from an occupational perspective. In this sense human experiences are embedded in particular situations and human endeavors may be placed within a transactional framework that supports improvements in people's lives (Cutchin & Dickie, 2012). Ethical approval for the study was obtained from the Regional

Committee for Medical Research Ethics in the Eastern Health Region, Norway (approval number 194-07084a1.2007.269).

Participants

This article addresses eight of the participants (five women and three men) included in a larger study published elsewhere (Lund, Michelet, Sandvik, Wyller, & Sveen, 2012; Lund, Michelet, Kjekken, Wyller, & Sveen, 2012). The participants provided their written, informed consent to participate following a written and oral explanation of the study. The inclusion criteria were that participants had been admitted to hospital with a clinical diagnosis of stroke as diagnosed by a physician, were over 65 years of age and able to give written consent at time of discharge. They were also required to have a Mini Mental Status Examination (MMSE) score above 21 (max 30), indicating sufficient cognitive function (such as orientation, word recall, attention and calculations, language abilities and visuospatial ability) (Folstein, Folstein, & McHugh, 1975), and a Barthel Activities of Daily Living Index score ≥ 14 (max 20), thus excluding participants with a severe degree of dependence in personal activities (Laake et al., 1995; Mahoney & Barthel, 1965). The exclusion criteria were severe communication problems evaluated as a score above 33 (max 52) on the Ullevaal Aphasia Screening test (Thommessen, Thoresen, Bautz-Holter, & Laake, 1999). The scores of the assessments indicated that all participants had mild to moderate stroke. They were home-dwelling with an age range of 69-88 years. Further characteristics of the participants are displayed in Table 1.

<Insert Table 1 about here>

Data collection and analysis

Six focus group interview sessions (Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007) of approximately one hour each, were conducted by the first author. Each participant attended two group sessions. To facilitate exchange of the participants' experiences after

stroke, small groups of two or three participants were used. The participants did not know each other in advance. Their common interests were related to their experiences of living with a stroke for more than 3 months and their consent to participate in the study. The chosen venues were three different senior centres in the participants' local environment. Senior centres are open social meeting places for older adults to gather in the local area (Slagsvold, Daatland, & Guntvedt, 2000) and provided an appropriate environment for the interviews. The researcher had met all the participants at the hospital or in their homes before the group interviews, and these previous communications enhanced the participants' feelings of confidence in the group setting and enabled all of them to exchange and share their experiences. The sessions were structured as a dialogue where the opening theme had a wide perspective, to gain some insight into the participants' experiences with stroke. This was followed by more probing questions to capture information related to occupations of importance in the participants' daily lives. The guiding questions included: What do you do during an ordinary day?, Are there any activities with which you have problems?, Are there any occupations you miss being able to do? and Which occupations are important for you to do in your daily life?

In accordance with the qualitative framework, the researcher's positioning was of great importance in the process of analysing the material (Denzin & Lincoln, 2005). This study should be seen as a situated activity which located the researcher in the world, attempting to make sense of what the participants addressed (Denzin & Lincoln, 2005). The researcher's situated activity was influenced by being in a double role as the researcher and the focus group leader. She participated closely in the activity within the groups, while simultaneously maintaining the research focus. There were ongoing dialogues between the researcher and the participants that opened up interpretative and communicative processes, which was a task comprised of both acting upon and reflecting in action (Schön, 1987).

The researcher strove to understand how the group participants talked about their lives, which required her to talk and act in an open-minded way. At the same time, she brought in questions to explore the participants' experiences of occupations of importance within their social and cultural praxis. The researcher facilitated the interaction among the participants by listening and asking questions, thereby enabling them to reflect on, and exchange, experiences that they found important in their lives (Halcomb et al., 2007). A second leader was present at the focus group sessions as a participant observer, and helped ensure a fresh exchange of reflections after each session. This enabled a deeper understanding of the interactions that had occurred.

The interview sessions were audiotaped and transcribed verbatim. All writings were interpretations of interpretations (Geertz, 1973), and were further analysed in stages inspired by Giorgi (Malterud, 1993; Malterud, 2001). The transcribed written material was initially read several times to help obtain a general impression of how the participants presented themselves. The first impression revealed how they interacted with each other by addressing what they currently were doing related to what they had been able to do in the past.

Experiences with stroke were interpreted as 'interruptions' in their lives related to not being able to perform previous activities. This actualised categories close to their expressions such as: 'anxiety', 'other interruptions in their lives', 'to be old and handicapped', 'not to be able to be active' and 'feeling useless in society'. We further raised questions related to the material about how the participants lived out these interruptions in the Western cultural context.

The meaning units were then condensed and abstracted to meanings within each of the systems of categories. Finally, the contents of the categories were generalised and related to the participants' expressions about their lives after stroke and how they, in different ways, created meanings and changes in their desired occupations. Parts of the written material were read by experienced qualitative researchers, followed by group discussions which contributed

to rich descriptions closely related to the participants' experiences. These interpretations were further deeply discussed with the co-authors. The authors had varied backgrounds in health care, methodological qualifications and experiences from different research topics, thus enriching the critical questioning and discussions during the processes of data collection, analysis and interpretations.

Findings

The two main themes that emerged were the participants' presentations of their 'feelings' of having a stroke interpreted as an '*occupational threat*' intertwined with their 'doings' related to '*reconstruction of occupational balance*' in different ways. Occupational changes related to social exclusion were addressed by the participants in subtle ways and actualised feelings of restrictions in performing culturally valued occupations. However at the same time social inclusion was demonstrated in how the participants were actively involved in creating occupational balance.

The stroke as an 'occupational threat'

The participants exchanged experiences related to current interruptions in everyday life particularly related to occupations, such as managing their finances, driving the car, doing housework, travelling, reading books and taking care of great-grandchildren. These occupations were given positive cultural value related to being active, productive and useful in society and not being able to perform them generated feelings of social exclusion. Tiredness and reduced energy to perform positively valued occupations were also discussed. Feelings of occupational exclusion, imbalance, deprivation and marginalisation were revealed (Stadnyk et al., 2011; Townsend & Wilcock, 2004a, 2004b). These categories are socially constructed and some examples will be presented to illustrate how these transactions were negotiated and reconstructed within the Western cultural context of the study.

Occupational exclusion

The participants addressed their reduced opportunities for doing positively valued occupations. They constructed feelings of powerlessness and dependency in different ways. Restrictions in experiencing meaningful occupations were created. Erna described limitations related to her dependency on her daughter in order to pay bills.

To know that you are dependent upon others is a problem ...it is something to do with this feeling of powerlessness ... I feel paralysed to act.

Knut faced the feeling of dependency when he reflected upon not being able to drive his car, which he had been doing every day for more than 60 years:

It is really a pity that I am not allowed to drive the car any longer ...this brings me to be dependent upon others.

Occupational constraints influenced their dependency on help from others, which was given a negative cultural value. Their independence was threatened and seemed to create a sense of being socially excluded by being restricted from experiencing meaningful and enriching occupations (Hammell, 2008).

Occupational imbalance

All participants were concerned with their reduced energy and ability to carry out occupations that they had managed to do before having their stroke. An occupational imbalance was created in a variety of ways. Tiredness was revealed as a restriction in various occupations, as exemplified by Emma and Evelyn in relation to doing housework (vacuum cleaning and washing the floors).

Emma: I do not understand why I feel so tired ...I did manage so many things before. My husband has hired help for washing the floors.

Evelyn: I feel exactly the same, I do feel very tired and when I wash the floors I have to take many breaks and the vacuum cleaning has to wait until the next day.

Erna related her tiredness to previous leisure occupations such as travelling and reading books, and said:

I'm able to do very little [now] and I have always been travelling around, being very busy and doing many things all the time. Everything is a kind of 'effort' and I think I should do it [read the book] and I think yes, yes, yes, but not now.

Some participants talked about how they felt much slower when performing occupations, including reduced energy, feelings related to being disappointed and helpless as actualised by Knut:

Everything I do now takes a lot of time. I do feel very weak and disappointed. ...I don't have energy any longer. It is like the absence of energy and spark.

The participants' feelings of tiredness and lack of energy were related to their limitations in performing current meaningful and desired occupations. These feelings created a sense of being under-occupied that revealed a threat to carrying out meaningful occupations. In a culture in which being occupied, busy and active are positively valued, there seemed to be a lack of congruence between the participants' constructions of occupational opportunities and core values, hence creating occupational imbalance. In this sense occupational imbalance can be recognised as a lack of congruence across one's occupations, or between possibilities to perform occupations and cultural core values (Backman, 2011).

Occupational deprivation and marginalisation

The majority of the participants expressed their feeling of 'uselessness' and not 'being needed any longer' during discussions of occupations they missed being able to do. Occupational deprivation and marginalization were revealed to be closely linked together, and related to societal values and factors standing outside of the control of the participants. Erna said:

I miss doing tasks ... I would do tasks if I only had the strength... but anyway, one is redundant in society.

This illustrated that the feelings of being redundant can be related to a feeling of uselessness due to a reduced ability to do what she wanted to do, which was further underscored by Erna when she talked about her great-grandchild:

I am not able to take care of her alone any longer, because if she runs [away] very fast I will not be able to reach her, she is only three years old... I feel that I am not needed any longer.

Erna's feeling of no longer being productive might be interpreted as a way of addressing positive values by doing productive occupations. The participants addressed 'being old' and 'handicapped', which also revealed feelings of being 'useless', as expressed by Erna:

When you are both old and handicapped your limitations decrease your possibility to take care of yourself, but before (the stroke) I was very active.

This demonstrated that the participants' felt restrictions in occupations linked to positive values of how active they were before compared to their current occupational limitations. Being old and having a stroke revealed negative cultural values. This created their feeling of uselessness. Knut related this to being 'old' in society.

In the good old days children should be invisible, but today it is ourselves (who are old) who should be invisible in the society.

The participants perceived interruptions in performing culturally valued occupations related to being productive and active. This seemed to actualise negative values of being both old and having had a stroke. These cultural factors stood outside the control of the participants, and seemed to create their feelings of being useless and not being needed in society any longer. These examples of occupational threats exemplified feelings of preclusion from engagement in positively valued occupations, and feelings of occupational deprivation and marginalisation seemed to be constructed. This can be interpreted as occupational deprivation, as defined by Whiteford (2011) which can create stigmatisation. Occupational marginalization seemed to be

created by some participants, related to reduced opportunities to participate in occupations. This was revealed in subtle ways through expectations of how, when and where the person should participate in occupations (Stadnyk et al., 2011).

Summary of 'occupational threat'

In general, the participants' experiences seemed to reveal a major disturbance to their daily lives, which was demonstrated by discussions of their previous lives. They seemed to be influenced by positive cultural values related to being busy, occupied and productive and their current occupational limitations were revealed as an occupational threat. Feelings of occupational imbalance and deprivation were constructed. They also expressed limitations in being able to do occupations independently, which created feelings of occupational exclusion in different ways. In this sense, Western culture stands outside the control of the individuals, and may create feelings of social exclusion and marginalisation, which can further create stigmatisation. The participants' feelings of being redundant, useless, old and disabled were constructed, contested and manifested by themselves in mutual relationships with each other in this cultural context. Thus, the participants experienced their stroke as a threat to social participation and to performing meaningful occupations. At the same time, they reconstructed their 'doings' in a variety of new ways.

Occupational balance

The participants' 'doings' were expressed through how they performed their occupations, which was particularly revealed through how they reflected and addressed their enjoyable occupations by 'taking charge' in different ways.

Enjoyable occupations

Most of the participants had changed their ways of performing enjoyable occupations due to their limitations. This was particularly related to shopping, driving the car, going for a walk, dancing, knitting clothes for their family, hiking in the mountains, playing the piano and

visiting the church. Their statements addressed being productive, active and maintaining their rights to perform occupations as given positive values in their social and cultural context.

Erna exemplified this when talking about shopping, saying “*I need to do this because I find it enjoyable*”. Erna lived on the third floor without a lift, and used much energy climbing stairs. In the past, she went to the shopping centre on foot, but now she goes by taxi. Her daughter had advised her that she should *not* go shopping on her own due to the risk of falling and suffering a fracture. Erna appeared to ignore her daughter’s view, and chose to do her shopping on her own because she found it enjoyable and of great importance. Thus she reconstructed her way of shopping to enhance control, which was interpreted as a transaction for sustaining participation, control and autonomy in a desired occupation.

Evelyn and Emma presented examples of how they reconstructed their hobbies of ‘dancing’ and ‘knitting’. In the past, Evelyn had been dancing once a month together with her husband. After her husband died (four months previously), she continued to visit the dance venue, explaining that “*even though I’m not dancing now, I find it very nice to listen to the music*”. In changing her participation from ‘dancing’ to ‘listening,’ Evelyn created a new way of performing this occupation, which illustrated a transition to perform a positive meaningful occupation. Karl also changed his perception of one of his important occupations which had been to play the piano.

My fingers do not work very well any longer ...but I do enjoy listening to music instead [of playing the piano].

Emma was very fond of knitting, and said that she had made many sweaters and cardigans by pattern knitting. Since her stroke, she had reconstructed this occupation:

I have not started with pattern knitting yet because I’m afraid I will not be able to follow the pattern. ...Now I only make socks for my children and grandchildren [laugh], and they are very happy with that.

This shift showed a transaction to sustain productivity that was given a positive value in this context. Equally, going for a walk in the forest, in the mountains or in the local area were addressed as enjoyable for many participants. After commenting that she “*used to hiking in the mountains, but my husband says this is impossible now,*” Emma explained how she had reconstructed this occupation:

*I try to go for a walk and at least I walk from my home to see the physiotherapist
...which is about half an hour.*

Evelyn said that after her husband had died she had been sitting at home a great deal of time, but she had recently started to go out for a walk in the local area and created this as a social situation.

*When I go for a walk or shopping and accidentally see somebody I know, I greet them
and sit down with them and have a chat ...you know when you are living alone and
meet with people it is easy [for me] to talk.*

Karl also presented a reconstruction of walking in the forest together with his wife, describing how “*we do try to walk in the forest, but only brief walks*”. Annelise had also been very fond of travelling and walking, but the stroke had left her with reduced balance. She adapted by using a walking frame, and expressed her reconstruction this way:

*It is very important for me to get out every day even though I only walk a few meters
...and when I come home I feel VERY satisfied because I went out for a walk.*

Similarly, she continued her regular Sunday worship in a new way:

*It is not easy to use the walking frame in the church so I'm now listening to the Sunday
service on the radio.*

Self-reflection

Some participants addressed their occupational constraints by self-reflection and finding other solutions. Knut addressed this when he presented his restrictions in driving his car. He accepted using the transportation provided by the local senior centre, and said:

It is a very big change, but the world doesn't fall apart either... you reach a kind of crossroads and find the best solution.

Additionally, Knut addressed the importance of having the possibility of choosing, and mentioned a strategy that illustrates the importance of maintaining a way of control:

I feel free, and if I wasn't offered transport, I could have come here by using a taxi.

Summary of occupational balance

The participants reconstructed new ways of understanding and performing occupations in relation to their current limitations. Positive values of being active, productive and busy were created, constructed, contested and maintained in mutual interactions with each other by addressing their desired occupations. These new ways seemed to aid in the maintenance of social participation, in order to regain control, autonomy, dignity and identity in their lives. This demonstrated how the participants in different ways reconstructed occupational balance and social inclusion in their lives.

Discussion

This study illustrates how older adults constructed, negotiated and experienced occupational transactions in everyday life in a variety of ways post stroke, including the construction of threat to social inclusion and carrying out meaningful occupations. At the same time, they reconstructed occupational balance by addressing enjoyable and desirable occupations. The participants seemed to be influenced by Western culture, which implies positive values of being active, productive and independent (Laliberte Rudman, 2005; Laliberte Rudman, & Molke, 2009; Sassatelli, 2007). Their reduced capability to perform occupations they had found to be valuable and meaningful actualised occupational imbalance, deprivation,

exclusion and marginalisation (Townsend & Polatajko, 2007). This might have had an impact on the participants' feelings of the rights to perform contextually valued occupations.

Occupational justice may be understood as social constructed (Stadnyk et al., 2011; Townsend & Wilcock, 2004a, 2004b) and negotiated, constructed and maintained by the participants themselves. This was especially exhibited through their expressions of tiredness, uselessness, powerlessness and dependency. Feelings of being useless and dependent have been previously documented among older adults after stroke, with negative feelings exacerbated by an inability to do valued activities related to the participant's pre-stroke identity (White et al., 2008). In a context in which a lack of energy, tiredness and dependency implies negative cultural values, their perceived occupational imbalance (Stadnyk et al., 2011) might influence stress, health and well-being (Backman, 2011).

The participants also described reduced capabilities to perform occupations they valued as positive, a deficit that probably created feelings of social and occupational exclusion (Hammell, 2008). This aligns with the findings of Ellis-Hill and Horn (2000), who found that stroke survivors (mean age 71.4 years), without severe communication, cognitive or perceptual difficulties reported decreased social activity, psychological morbidity and a negative sense of self. People who have had a stroke are often regarded as inactive, deserving of pity and presented in negative terms such 'stroke victims' (Pound et al., 1999). This is in accordance with our participants' constructions of the stroke as an occupational threat.

Interpreted in a Western culture, these attitudes seemed to be constructed, maintained and contested among the participants in our study. However, their perception of the stroke as an occupational threat simultaneously triggered their reconstructions of occupational balance by addressing their enjoyable occupations. Similar findings were documented by Kessler et al. (2009), in which the stroke survivors' experiences of vulnerability and occupational limitations threatened the sense of control in their lives and led to a reestablishment of a sense

of control. The participants' engagement in performing occupations in new ways is also supported by Pound et al. (1999), who found that after a stroke, people actively manage the aftermath by creating new ways of doing things that help begin the process of relearning. Our study supports the importance of creating an awareness of the individuals' competencies in developing coping strategies through their ways of creating occupational balance, particularly by performing enjoyable occupations in new ways. The participants seemed to construct meaningful occupations in order to help maintain occupational balance, control and autonomy. These capabilities are linked to dignity and the right and opportunity to do occupations that matter for people; and is an important outcome in rehabilitation (Siegert & Ward, 2010). In addition, the maintenance of autonomy as an important aim in the care of people who have had a stroke is stressed due to that quality of life is negatively influenced by perceived loss of autonomy (Proot, Abu-Saas, & Crebolder, 2007). 'Taking charge' is also demonstrated as being important to help improve the outcome for people from different cultures who have had a stroke (Harwood et al., 2011).

Cutchin and Dickie (2012) referred to Dewey and address that if people are to function and to maximize function it is not sufficient to think about a person acting independently of an environment. There is constant coordination of the relationship between the environment and the person. This active coordination is very subtle and unrealized, and has been more explicitly revealed in our study. Thus functional coordination can be viewed as 'transaction' via the dynamic, coordinated restructuring of relationships of person and situation (Cutchin & Dickie, 2012).

The participants' competencies illustrated in our study should be recognised in enabling an occupationally just world with an individual's right to participate in daily occupations. Our study illustrates how older adults engaged in transactions in different ways to help enhance control, autonomy and occupational balance after a stroke. Within the traditional

rehabilitation discourse, people who have had a stroke are often closely associated with their medical condition (Ellis-Hill, Payne, & Ward, 2008). Ellis-Hill et al.'s (2008) alternative approach to understanding rehabilitation incorporated identifying hidden psychological and social processes as well as physical aspects by using narratives. They suggested viewing acquired disability as a time of transition rather than loss that may create positive futures for people in rehabilitation.

Our findings exemplify how older adults, in different ways, were trying to find 'the new me' and how they were actively making sense of what had happened and were trying to work towards social inclusion. This points to the importance of focusing on abilities and on new possibilities in order to create positive futures (Ellis-Hill et al., 2008). Our findings illuminate how the participants created meaning and a positive personal identity through occupational changes. This can be supported by Matuska and Christiansen's (2008) proposed Lifestyle Balance Model and may contribute to reduced stress, improved health and well-being.

Methodological considerations

Each focus group consisted of two or three participants, which might have limited the richness of the group discussions. However, a small group gave the participants opportunity to share their insights and allowed them to easily share their experiences. The interactions with peers who had experienced a stroke seemed to enable the participants to compare themselves with others, as a way of constructing an optimistic and self-reflective perspective of their lives (Kessler et al., 2009). This might have influenced the results in the study. Additionally, as in most qualitative studies, the number of participants was limited. This means that they did not represent other people with the same characteristics, but rather provided more in depth insight into a few people where the findings may be related to similar situations (Denzin & Lincoln, 2005).

The context of the interviews was senior centres, which also could have influenced the findings. Older adults attending a senior centre may regard this as being a meeting place only for very old, frail and sick people. A 'sense of threat' can be revealed that could have created a distance towards those that they perceived as more frail than themselves, while at the same time creating a sense of thriving (Lund & Engelsrud, 2008). This may have contributed to the actualisation of negative values related to being old and having had a stroke as interpreted in a Western cultural context.

The participants did not have any severe communication problems, so the results only address older adults who are able to communicate. However, the study provided insights into the experiences that these individuals had in living with a stroke as they willingly exchanged their thoughts and ideas about their daily lives. The validity in qualitative research depends on the researchers' efforts to question their own preconceptions and to make detailed, accurate analyses (Denzin & Lincoln, 2005). The various backgrounds of the researchers in the current study influenced the way we asked questions during the analysis, which enriched the interpretation.

Conclusion

This study describes eight older adults' experiences of occupational changes in their everyday lives after having had a stroke, which are analysed within a Western cultural context. The participants' experiences provided insight, in different ways, as to how they felt the stroke as, an occupational threat, constructed as social exclusion and a lack of dignity; but which at the same time triggered their reconstruction of occupational balance, control and autonomy. The participants' experiences post stroke demonstrated their competencies in reconstructing occupational balance by performing desirable and enjoyable occupations in new ways. Everyday life after stroke is suggested to be seen as a time of transaction, when people are actively involved in creating control, occupational balance and being socially included. In

practice and in further research this may guide politicians, governments, communities and health professionals, regarding ways to enable the right to experience meaningful occupations to enhance health and well-being.

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Table 1: Characteristics of the Participants

Participants (pseudonyms)	Sex	Age	Marital status	MMSE score¹ (max score 30)	Barthel score² (max score 20)	UAS score³ (max score 52)
Centre 1						
Knut	Male	70	Unmarried	29	20	52
Erna	Female	87	Widow	30	17	52
Inga	Female	88	Widow	21	20	52
Centre 2						
Emma	Female	69	Married	28	20	48
Evelyn	Female	72	Widow	29	19	52
Centre 3						
Annelise	Female	83	Unmarried	28	19	52
Karl	Male	81	Married	27	20	52
Ola	Male	71	Married	22	18	38

¹MMSE-Mini Mental Status Examination, ²Barthel Activity of Daily Living Index, ³UAS-Ullevaal Aphasia Screening Test