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Physiotherapists' and clients' accounts of treatments, and observed interaction during group sessions

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Tiivistelmä

Kotona asuvat vanhukset laitoskuntoutuksessa

Fysioterapeuttien ja asiakkaiden kuntoutuskertomukset ja vuorovaikutus ryhmätilanteiden aikana

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Abstract

Wallin M. **Community-dwelling older people in inpatient rehabilitation. Physiotherapists' and clients' accounts of treatments, and observed interaction during group sessions**. Helsinki: The Social Insurance Institution, Finland, Studies in social security and health 103, 2009. 148 p. ISBN 978-951-669-795-9 (print), 978-951-669-796-6 (pdf).

The aim of this study was to examine the situated praxis of group-based physiotherapy in geriatric inpatient rehabilitation aimed at frail community-dwelling older adults. The data were collected from the AGE study during 2002 and 2003, and comprised 31 interviews with older adults aged 66–93 years and 11 physiotherapists. In addition seven group exercise sessions comprising 52 older adults and 9 professionals were videotaped. Transcribed texts from interviews and videotaped sessions were analysed qualitatively. The older adults described their rehabilitation experience as giving them a sense of confidence in their everyday living, as a sense of being in a vacation or as a sense of disappointment. The physiotherapists described the older adults either as recipients of rehabilitation intervention focusing on their physical functional ability or social needs, or as partners in an exercise intervention to enhance their ability to cope at home. The group exercise sessions were carried out according to the agenda of the physiotherapists either in a structured manner without individualised modifications or allowing individual adjustments and feedback. Circuit training allowed greater opportunities for older adults to participate actively in the session consisting of taciturn exercising, submissive disagreeing, resilient endeavouring and lay helping. The heterogeneity of the group posed a challenge to the mundane praxis of rehabilitation, illuminating its strengths and suggesting areas for further development. Allowing and enabling team efforts by older adults' during exercise sessions provide meaningful social interaction and togetherness. Older adults' initiations and independent actions together with joint problem solving are important skills when considering the challenges of independent living in the community. Knowingly practising the link between activities during physiotherapy and everyday living through daily tasks enhances the opportunities for the adoption of these new skills.

Keywords: living at home, elderly, rehabilitation, exercise therapy, functional ability, rehabilitation clients, interaction

Tiivistelmä

Wallin M. **Kotona asuvat vanhukset laitoskuntoutuksessa**. **Fysioterapeuttien ja asiakkaiden kuntoutuskertomukset ja vuorovaikutus ryhmätilanteiden aikana**. Helsinki: Kela, Sosiaali- ja terveysturvan tutkimuksia 103, 2009. 148 s. ISBN 978-951-669-795-9 (nid.), 978-951-669-796-6 (pdf).

Tutkimuksen tarkoitus oli selvittää kotona asuvien vanhusten laitoskuntoutuksen liikunnallisen osuuden toteutumista fysioterapeuttien ja vanhusten näkökulmasta. Tutkimuksen aineisto kerättiin vuosina 2002 ja 2003 Kelan IKÄ-hankkeen kuntoutusryhmistä. Tutkimukseen haastateltiin 31 iältään 66–93-vuotiasta kuntoutujaa ja 11 fysioterapeuttia. Lisäksi videoitiin seitsemän ryhmäliikuntatilannetta, joihin osallistui yhteensä 52 vanhusta ja 9 ammattilaista. Vanhukset kuvailivat kuntoutuskokemustaan joko arjessa selviytymisen välineeksi tai lomaksi arjesta. Osa oli pettynyt saamaansa kuntoutukseen. Fysioterapeutit pitivät vanhuksia joko kuntoutuksen vastaanottajina, jolloin keskityttiin vanhuksen fyysisen toimintakyvyn ongelmiin tai sosiaalisiin tarpeisiin, tai kumppaneina harjoitteluinterventiossa kotona selviytymisen edistämiseksi. Ryhmäliikuntatilanteet etenivät fysioterapeuttijohtoisesti, joko strukturoidusti ilman kuntoutujille annettua yksilöllistä palautetta tai yksilöllisen ohjauksen ja palautteen mahdollistaen. Ns. kiertoharjoittelussa vanhuksilla oli mahdollisuus osallistua aktiivisesti liikuntaryhmän toteuttamiseen. Vanhukset osallistuivat *hiljaisesti harjoittelemalla*, *vastentahtoisesti suostumalla*, *sitkeästi yrittämällä* tai *kaveria auttamalla*. Heterogeeninen vanhusryhmä haastaa nykyisiä kuntoutuskäytäntöjä, joissa on sekä toimivia että kehitettäviä alueita. Vanhusten kotona asumista heidän yksilölliset tarpeensa huomioon ottaen voidaan tukea, kun vanhukset saavat osallistua muiden ryhmäläisten kanssa yhteiseen ongelmanratkaisuun ja heille mielekkäiden, arjen askareita tukevien harjoitusten tekemiseen. – Yhteenveto s. 52–56.

Avainsanat: kotona asuminen, vanhukset, kuntoutus, liikuntahoito, toimintakyky, kuntoutujat, vuorovaikutus

Sammandrag

Wallin M. **Äldre människor i kommunalt serviceboende som deltar i rehabilitering. Fysioterapeutens och klienternas redogörelse för rehabiliteringen och interaktionen under gruppövningarna**. Helsingfors: FPA, Social trygghet och hälsa: Undersökningar 103, 2009. 148 s. ISBN 978-951-669-795-9 (hft.), 978-951-669-796-6 (pdf).

Syftet med denna forskning är att kartlägga hur fysioterapin genomförs på rehabiliteringskurser för äldre människor i kommunalt boende, både ur fysioterapeutens och klientens synvinkel. Undersökningsmaterialet samlades in åren 2002–2003 i ÅLDER-projektets rehabiliteringsgrupper. I studien intervjuades 31 klienter mellan 66 och 93 år och 11 fysioterapeuter. Dessutom videofilmades sju gruppövningar med 52 äldre människor och 9 instruktörer. Intervjutexterna och videoupptagningarna analyserades med kvalitativ forskningsmetodik. De äldre beskrev rehabiliteringsupplevelsen så som att man med större säkerhet kunde klara vardagen eller att det var som att vara på semester. En del av deltagarna i grupperna var dock besvikna på rehabiliteringen. Fysioterapeuterna beskrev de äldre som mottagare av rehabilitering och fokuserade på fysisk funktionsförmåga eller socialt behov. En annan tolkning var att man deltog som träningspartners i de övningar som syftade till att underlätta ett självständigare liv hemma. Gruppövningarna genomfördes under ledning av en fysioterapeut, antingen i strukturerad form utan individuell anpassning eller med individuell handledning och feedback. Cirkelträning tillät i större utsträckning de äldre att aktivt delta och inverka på genomförandet av gruppträningen. Deltagarna utförde övningarna under tystnad, stundtals under protest, men kämpade ändå ihärdigt och hjälpte vid behov även kamraterna. Att rehabilitera heterogena grupper av äldre människor är en utmaning för rehabiliteringspraxisen, inom vilken det finns både fungerande områden och sådana som behöver utvecklas. Det är möjligt att göra det lättare för äldre människor att bo hemma och att samtidigt ta hänsyn till deras individuella behov genom att låta dem aktivt få delta i problemlösning och i gruppträning som syftar till att underlätta vardagen.

Nyckelord: hemmaboende, äldre, rörelseterapi, funktionsförmåga, rehabiliteringspatienter, växelverkan

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Espoo, September 2008

Marjo Wallin

CONTENTS

LIST OF ORIGINAL PUBLICATIONS

The thesis is based on the following papers, which will be referred to by their Roman numerals.

I **Wallin M; Talvitie U; Cattan M; Karppi S-L.** The meanings older people give to their rehabilitation experience. Ageing & Society 2007; 27: 147–164.

II **Wallin M; Talvitie U; Cattan M; Karppi S-L.** Physiotherapists' accounts of their clients in geriatric inpatient rehabilitation. Scandinavian Journal of Caring Sciences 2008; 22: 543–550.

III **Wallin M; Talvitie U; Cattan M; Karppi S-L.** Construction of group exercise sessions in geriatric inpatient rehabilitation. Health Communication 2008; 23: 245–252.

IV **Wallin M; Talvitie U; Cattan M; Karppi S-L.** Interaction between clients and physiotherapists in group exercise classes in geriatric rehabilitation. Advances in Physiotherapy 2008 (DOI: 10.1080/14038190802538948).

Original publications are available in the print version only.

1 INTRODUCTION

Population ageing presents an extensive challenge world-wide. In Finland the change in the age structure is expected to take place more rapidly than in most other European countries (Nieminen and Koskinen 2006). The national strategies in old-age policy in Finland emphasise the importance of independent living at home (Ministry of Social Affairs and Health 2001 and 2008). Taking into account the high prevalence of long-term illnesses and impaired functional ability (Teperi and Vuorenkoski 2006), preventative and rehabilitative measures have been stressed to secure functional independence in old age (Ministry of Social Affairs and Health 2008). Geriatric rehabilitation of older adults to enhance their ability to remain community-dwelling has been defined as an important future task of health care in Finland (Finnish Government 2002; Heikkinen 2006; Teperi 2006). In order to develop and assess the effectiveness of an inpatient rehabilitation model to support the community living of frail older people at high risk of institutionalisation, in 2002, the Social Insurance Institution of Finland initiated the AGE Study (Hinkka et al. 2006; Ollonqvist et al. 2007). While the randomized controlled trial was implemented to investigate the efficacy of the intervention, there was also a parallel need to gain a comprehensive understanding about the content of rehabilitation intervention. Several sub-studies were initiated, including the present study, which focused on physiotherapy.

Geriatric physiotherapy aims to increase patients' independence and quality of life by restoring and maintaining an optimal level of physical function despite the disabling effects of diseases and injuries (Felsenthal et al. 2000; Jonsson et al. 2003). In order for patients to undertake an often long and arduous rehabilitation process, it is important at the outset to take patients' concerns into account so as to make the aims of rehabilitation meaningful, jointly negotiated and realistic (Sluijs et al. 1993; Young 1996; Reynolds 2005). This is also in accordance with the National framework for high-quality services for older people, which emphasises ensuring dignity in old-age services by securing the right to self-determination and participation, and providing individualised and resource-oriented care (Ministry of Social Affairs and Health 2008). Patients' perceptions of the patient centredness of the health care encounter, that is, establishing a shared agenda, including mutually agreed goals, has been found to be directly associated with improved health status and increased efficiency of care (Stewart 1995), as well as increased adherence to treatments (McDonald et al. 2002). Thus, an important element of the physiotherapy process is the active involvement and commitment of patients to rehabilitation (Young 1996; Kivekäs 2006).

Despite this widely accepted premise, there is relatively little knowledge about how it is put into practice in physiotherapy. To date, communication practices in physiotherapy, especially interaction during actual encounters, have received relatively little research attention (Reynolds 2005). In addition, little is known about communication during group sessions, as the existing studies have mainly focused on individual treatment encounters (Thornquist 1997; Martin 2004; Parry 2005; Talvitie and Pyöriä 2006). The present study explored the situated practice of group-based physiotherapy. The

specific objectives were to approach this issue through interview accounts with older adults and physiotherapists, and by investigating interaction during actual group exercise sessions.

2 INTERACTION BETWEEN PATIENTS AND PROFESSIONALS IN THE INSTITUTIONAL SETTING

It has been argued that, due to participants' orientation to the institutional context of the interaction, encounters between professionals and lay people evolve differently from mundane interaction between peers. Several features of interaction have been proposed as typical in institutional settings (Drew and Heritage 1992). First, institutional interaction is goal-oriented to some core goal conventionally associated with the institution. This goal-orientation may, however vary widely in different institutional settings. The participants may have a joint understanding of the main goal of the interaction from the outset or this goal starts out vague and is negotiated in the course of the encounter. In addition, the conduct of professionals is influenced by institutional and professional constraints and responsibilities, which may be unknown to the lay participants. Second, institutional interaction frequently involves constrains on allowable contributions to the evolving encounter. These constraints work in variety of ways, from limiting the actions to the task at hand to restricting the conversational contributions of some participants. Third, institutional interaction involves special assumptions and reasoning, which help the participants to interpret each others' conduct.

Early work on medical interaction revealed asymmetrical relationships between patient and doctor, owing to restricted information delivery to patients (Byrne and Long 1989). Further work on medical consultations suggested that clinical encounters are not always asymmetrical (ten Have 1991), but contextual problems, such as patients' non-compliance, can trigger an asymmetrical interactional response (Barton 2000). Moreover, a trajectory of practitioner approaches has been identified in clinical encounters between patients and health care professionals. Heritage and Sefi (1992) found in their study that a substantial majority of nurses' advice delivery cases were unilateral without any indication being given of need of advice. Furthermore, advice was not individualised to fit clients' specific situation or level of prior knowledge. Collins et al. (2005) examined decision-making in medical consultations and noted that 'more bilateral' and 'more unilateral' approaches can be identified across different clinical settings. The more bilateral approach featured mutual negotiations comprising elaborations on patients' perspectives, the comprehensive sharing of information about tests and treatment options and granting patients opportunities for making choices. In the more unilateral approach, decision-making was conducted autonomously by the practitioner without providing an opportunity for the patient to participate in it. Poskiparta et al. (2001) examined counseling sessions between nurses and patients and identified nurse-centered and empowermental health counseling sessions. Nurse-centered counseling sessions proceeded according to the professional's agenda, and the advice was delivered irrespective of the patients' needs. In the empowermental counseling sessions nurses emphasised patients' rights to speak up, utilised patients' perspectives in information delivery, and supported patients' reflection skills.

While the examination of professionals' communication practices is a fundamental task, the other party to the dyad in this interaction is the patient. Thus, it is essential to explore the patients' role in institutional interaction and how patients participate during clinical encounters. Patients are found to regularly withhold responses to doctors' diagnostic statements (Heath 1992; Peräkylä 2002) and to advice given by nurses or counsellors (Kettunen et al. 2000; Silverman 2001). Various reasons have been suggested for patients' silence and adaptation to the agenda of health care professionals, such as trusting the expertise of professionals and leaving decisions to them, displaying compliance and attentive listening, feelings of incompetence and guilt about health issues, and performing in institutionally correct, non-problematic ways (Kettunen et al. 2001b). The infrequent cases of patients' extended responses were related to both incongruency between doctors' views of the condition and patients' expectations during medical encounters (Heath 1992), and doctors' elaboration of the evidence for diagnostic conclusions in uncertain or conflicting diagnoses (Peräkylä 2002 and 2006). Whilst patients' extended responses after doctors' delivery of diagnoses (Heath 1992; Peräkylä 2006) are treated as problematic, patients' are expected to participate in recommendations for treatment (Stivers 2006). Recommendations for treatment are typically accepted by patients and if no confirmation is provided, doctors solicit the patient's agreement (Stivers 2005). Thus, withholding acceptance or resisting recommendations has been found to influence physicians' recommendations for treatment (Stivers 2002 and 2005). These findings revealed both patients' expectations regarding the conclusive authority of medical professionals and the adoption of an active and knowledgeable position (Peräkylä 2006; Stivers 2006).

In order to understand the interaction between health care professionals and patients in institutional settings, it is crucial to focus on the relationship rather than on the isolated actions of the one participant. Each encounter evolves turn by turn as the parties produce accountable patterns of meaning, inference and actions in the particular institutional context (Drew and Heritage 1992). The picture that emerges is complex. Particular institutional contexts undoubtedly have standard encounter patterns supported by both professional practices and physical objects (Drew and Heritage 1992; Scollon 2001), but at the same time these social and physical environments can been seen as providing opportunities for relationships, for interaction between the parties, which can shape the activity at hand (Heritage 1984).

2.1 Older people in geriatric health care contexts

Older people as patients in health care contexts poses an additional challenge for all the parties involved. Older patients themselves report negative experiences with health professionals in which they were neglected or treated as unimportant. Their views were not consulted about major decisions regarding their health and lives, which undermined their sense of autonomy. They perceived that they were expected to quietly assent to pain, discomfort and lack of information. These discriminatory practices in health care systems have been argued to perpetuate in older people a

sense of powerlessness in the face of illness (Minichiello et al. 2000). Roberts (1994) argued, after exploring older patients (70 +) experiences, that patients' stories mostly reflected a passive role, in which they were merely informed about decisions already made by the professionals. Overall, age-discriminatory, so called ageists practices in health care have been thought to stem from a variety of sources, such as professionals' personal biases towards old age (Wilkinson and Ferraro 2004) and health care policies excluding older patients from medical care (Simms 2004). These strong claims appear to be supported by empirical findings from situated encounters between older people and professionals during everyday practices in variety of health care settings.

Latimer (1997 and 1998) studied the care of people aged 75 and older, admitted to acute medical wards in a hospital. She found constant assessment and categorisation of patients by medical and nursing staff in order to maintain the flow of patients through the ward and to avoid blocked beds. This was accomplished by classifying patients according to status or potential. Patients judged as acutely ill were defined as 'medical' and thus, as having a medical future in the ward, whereas the patients appraised as chronically ill or having psycho-social problems were defined as 'social', meaning not appropriate to an acute ward and thus in need of discharge. The researcher argued that older people with several chronic conditions were vulnerable in this context, being easily seen as 'geriatrics', i.e. frail, old and lost the use of their legs and thus inappropriate for acute ward. In the same vein, Becker (1994) found that rehabilitation ward staff ranked stroke survivors into "rehabilitation candidates" or recipients of "geriatric care" in a hospital specialised in geriatrics. In this categorisation of older patients, the underlying principle was not only their physical level of disability but also their adherence to values of perseverance, self-reliance, determination to recover and positive attitude. "Rehabilitation candidates" were perceived to have good recovery potential, including the potential to tolerate aggressive rehabilitation and to meet professionals' therapy goals. In contrast, "geriatric care patients" were seen as in need of "babysitting", and in fact blocking beds from the potential rehabilitation candidates. Furthermore, differential treatments were administered to these different categories of patients. The therapists favoured patients considered as rehabilitation candidates by encouraging and providing them with more opportunities, and setting their goals differently from those of patients considered to be geriatric care recipients. In contrast, geriatric care patients were subject to infantilisation and the removal of adult status. During the activities of daily living the staff did not encourage these patients to independence, but rather treated them as if they were children. During the therapy sessions the geriatric care patients were not encouraged nor provided with explanations about the exercises, but implicitly threatened in an effort to get them to adhere to the training. The patients vacillated between resistance and efforts to please and comply with the therapists. In similar manner older people as patients in acute medical wards conformed with the categorisation by subduing and effacing themselves as personal and social beings (Latimer 1999).

McCormack (2001), who studied interaction between nurses and older people in hospitals, argued that older patients were not only amenable, but also allowed professionals

and relatives to disregard their expressed wishes. He suggested that older patients' limited participation in care decisions was due to internal and external factors, both of which limited the discursive rights of the patient. Internal factors referred to older people's expectations of the medical services, including their perception of the role of nurses and nurses' attitudes toward older people. This was supported by Roberts (1994), who argued that patients' perceptions of the meaning of participation can further hinder their involvement in their care. She illustrated a widespread view of participation amongst older patients by quoting a 74-years-old male patient: 'I think I have been pretty well involved. They've told me what they were going to do, and they've done it.' Moreover, external constraints pertaining to organisational policies, the use of language as a form of control, and routinised professional practices were found to limit patients' discursive rights (McCormack 2001). McWilliam et al. (1994) argued that professional practices that limited patients' active involvement were disempowering, especially to older patients with increased vulnerability. One such professional practice that has been found to be constantly in operation is the implicit assessment of individual patients' competence in decision-making (McCormack 2001). Patients' ability to make decisions was rarely discussed with patients themselves, but it was implicitly questioned until objectified through an assessment. Even then, other 'objective' assessments, such as family members' views, were judged as more reliable than the perceptions of the patients themselves. Thus, the researcher concluded that in the hospital context older people's opportunities to participate in care decisions were limited through lack of negotiation, control of conversation agendas and failure of professionals to respond to patients' cues.

Older people have been found to have limited opportunities not only in care decisions but also in self-care activities. Baltes and Wahl (1992) compared care practices and behaviours in community and institutional settings. They studied interaction between elderly participants (65 +) and family members and home health nurses in private homes and in interactions between elderly patients and staff in a private nursing home and a home for the chronically ill elderly. They found that in both settings dependent self-care behaviours of older people were reinforced by the caregiver. They argued that dependent behaviours secured immediate and predictable support from the care-givers, and thus provided an instrument of control for older people. While having the deleterious effects of increasing dependency, it also contained gains in achieving predictable social relations, including support and physical contact. They also noted that in the institutional settings independent self-care behavior was mostly ignored. In contrast, in community settings such independent behaviors were sometimes followed by a supportive response from the caregiver, although the most common response was incongruent, there by encouraging dependent behavior. This finding was supported by Moore (2004), who studied patterns of activity within the physical setting of an adult day care centre for people in the early stages of dementia. He found that the "core pattern" was 'Constraining Choices', which consisted of decreasing opportunities for personal control, emphasizing routine, and limiting participant independence. This was accomplished by having the staff in control of the primary activity for the day, and by limiting older people's access to physical areas and activities within them,

such as recliners, TV, piano and crafts. Older adults were kept in the main activity room for most of the day engaged in the same activities, making constant surveillance easier for the staff. The researcher argued that efforts at maintaining order resulted in infantilising the clients with dementia.

Rigid rules and procedures have been found to limit older people's opportunities for active participation and autonomy also in rehabilitation (Proot et al. 2000; Ballinger and Payne 2002; Whyte and Hart 2003). Ballinger and Payne (2002) studied the practices of a day hospital for community-dwelling older adults needing rehabilitation and medical treatments. They found that the service providers, who were nurses and therapists, orientated to physical risk and its minimisation during the day. The daily routines perpetuated this orientation; meals and drinks were served to the tables, personal help was provided without any indications of the need of it, and unnecessary physical activity was discouraged. Thus, the older people were less mobile and used fewer skills than in their own homes. The researchers concluded that the emphasis placed on physical safety during the daily practices discouraged the older people from independent daily activities, reinforced passivity and undermined their confidence. (Ballinger and Payne 2002.) This resembles the findings of Proot et al. (2000), who studied older patients with stroke in the rehabilitation ward of nursing homes. They stated that professional practices, such as staff deciding for patients on such matters as treatment plans, leisure activities or toilet times, constrained the older people's sense of independence and self-determination. Hart et al. (2005) argued that many of the activities during rehabilitation were aimed at adapting older patients to the norms, expectations and values of the institution, which can sometimes undermine the primary purpose of rehabilitation.

2.2 Patient encounters in physiotherapy

Interpersonal exchanges between physiotherapist and patient tend to be taken for granted and left unexamined, with the result that relatively few studies have been carried out on communication in physiotherapy settings (Reynolds 2005, 13). Arguably, this is because physiotherapy is firmly grounded in the medical model (Roberts 1994; Ritchie 1999; Reynolds 2005; Nicholls and Cheek 2006). This is manifested by a dualistic biomedical frame of reference: on the one hand a seeking after objective and context-free knowledge, and on the other viewing the client's body as the object of treatment intervention (Roberts 1994). Whereas the practitioners are assumed to act in the patients' best interests in order to maximise functioning, the patients' expressed needs and experiences are considered secondary to the practice of biomedicine. This shortcoming was already noted by Ramsden (1968), who stated "Physical therapists accept the viewpoint that it is necessary to treat the whole patient rather than an isolated disease entity or disability. Nevertheless, we still tend to focus attention on physical aspects of the patient and neglect psychological aspects, possibly because we are well-trained to handle the former but feel inadequate to deal with the latter. Failure to cope with the patients' emotional needs may not only mean that we are do-

ing half a job, but may also undermine the physical aspects of treatment." (Ramsden 1968, 1130). Furthermore, it has been argued that these premises are revealed by the 'clinician-centred' patterns of interaction that exist between health care professionals and their patients. Gallois et al. (1979) were among the first researchers to document dominant and one-sided interaction patterns among physiotherapists and their patients. They video-recorded physiotherapy treatment sessions and explored the non-verbal behavior during the physiotherapist-patient interactions. They found that physiotherapists spoke, on average, five times as much as patients, while patients were speaking in one-word sentences, such as "yes" and "no". Nonetheless, there has been a long-standing emphasis on the need for a patient-centred approach in physiotherapy (Ramsden 1968 and 1975; Goldin et al. 1974; Hamilton-Duckett and Kidd 1985; Ramsden and Taylor 1988; Sim 1986; Coy 1989). Reynolds (2005) noted that the dominance of the biomedical perspective has been increasingly challenged by alternative ways of conceptualising health, disability and illness, such as the biopsychosocial perspective and the social model of disability. She argued that these re-conceptualisations require changes in the patterns of interaction between health professionals and patients. In the literature on professional standards and expert practice, patient-centred and collaborative physiotherapy practices are nowadays considered axiomatic (Jensen et al. 2000; Mead 2000; Higgs et al. 2001; WCPT 2008). Jensen el al. (2000) explored the dimensions of clinical expertise in physical therapy and identified four elements of clinical expertise that were all penetrated by physiotherapists' strong commitment to their patients and families. Their clinical specialty *knowledge* was patient-centred and they used contextual collaboration in their *clinical reasoning*. *Movement* was their central focus and they emphasised patients' ability to function in their everyday lives. Their *virtues* were caring for and commitment to their patients. Further empirical research on communication in physiotherapy encounters, however, suggests that the process of involving patients in physiotherapy in a meaningful way continues to present a challenge.

The earliest, published, empirical study on communication in physiotherapy encounters dates back to 1975. In this observational study patient-physiotherapist interaction during treatment sessions was analysed, focusing on non-verbal communication (Perry 1975). The results suggested that all interactions observed included some nonverbal communication; however the patients and the physiotherapists were aware of the nonverbal behavior for only approximately 50% of the time that such behavior was noted. Gallois et al. (1979) utilised more advanced data collection techniques and video-recorded patient-physiotherapist interaction during treatment sessions. They found that non-verbal behaviors differed as a function of the sex of the physiotherapist, the sex of the patient and the point in the interaction. However, common to these non-verbal behaviors was their one-sidedness and the physiotherapists' dominance. In contrast, Ek (1990) found that physiotherapy treatment situations were jointly co-produced by the patient and the therapist, when video-recordings over the course of physiotherapy treatments were analysed. On the other hand Thornquist (1990, 1991, 1992 and 1994a) conducted a comparative study of first encounters between patients and physiotherapists in a variety of settings. She video-recorded and interviewed

physiotherapists specialised in manual therapy, psychomotor therapy and home visits. She found that in the encounters the context was created by the physical actions of the therapist as the active party and the patient as the passive one, combined with the physical closeness and dialogue between them (Thornquist 1992). In Finland, Talvitie (1996 and 2000) analysed video-recorded physiotherapy treatment sessions focusing on the physiotherapists' verbal, visual and manual guidance and the patients' verbal and physical responses. The findings indicated that the physiotherapists extensively used verbal and manual guidance. The main mean of instructing patients was to name the next exercise and to ask them to take up the correct position for starting the movement. The physiotherapists rarely discussed the goal of the therapy or the importance of a particular exercise in the context of the total rehabilitation programme with the patients (Talvitie 1996). In addition, the feedback given by the physiotherapists' was motivational and reinforcing. Information feedback was rarely used. Verbal cues were mostly short comments, while manual cues were used to guide the patients to produce the correct movements (Talvitie 2000).

The picture that emerges of physiotherapy encounters is somewhat incoherent. While claiming to embrace client-centred approaches during rehabilitation, physiotherapists' embodied practices during encounters did not reflect this (Baker at al. 2001), nor was it obvious to their patients (Wohlin Wottrich et al. 2004). This uncertainty in professional orientation was also displayed in Westman Kumlin and Kroksmark's (1992) interview study of physiotherapists, who were asked to describe their actions during their first encounter with patients. Two rather incompatible approaches were found, the dialogical approach and the authoritative approach. In the dialogical approach, the physiotherapists aimed at discovering the patients' own conceptions of their problems and strategies for solving them. In the authoritative approach, the physiotherapists' conceptions dominated with regard to the patients' problems and solutions. Subsequently, Beeston and Simons (1996) found, in an interview study among physiotherapists, that their values were patient-centred, their knowledge was practice-oriented, and their practical actions were specific to the profession. While endorsing collaboration with patients, in practice, however, the physiotherapists grounded their actions on biomechanics and neurophysiology, and focused on the recovery of normal movement. Thornquist (1994b) found that physiotherapists wavered between attending to their profession's biomedical frame of reference and to their intuitive relating to the patients as embodied subjects. This occurred when the physiotherapists bypassed a patient's experiences in the professional context but, nevertheless, related to the patient in their general interaction. She argued that this inconsistency was due to unintegrated worlds of knowledge on the part of the physiotherapists. Although Jorgensen's (2000) findings confirm that physiotherapists commonly prioritised their professional agenda and the physical capability of patients, leaving little or no room for the patients to influence the content of the physiotherapy regimen, she did find an alternative situation. In this alternative approach, the physiotherapist allowed the patients to elaborate on their experiences, expectations, leisure-time activities and home situation. This alternative, more patient-centred approach, however, appears to be a rarity.

That actively participating in and influencing physiotherapy treatments constitutes a challenge is reflected in the patients' accounts. Patients perceived that they were not allowed to be involved in a meaningful way in decision making regarding physiotherapy treatments (Payton et al. 1998; Röding et al. 2003; Wohlin Wottrich et al. 2004). Patients recovering from stroke expressed frustration with their rehabilitation process owing to a perceived lack of participation and information, invisibility, and insufficient and mal-adapted rehabilitation (Röding et al. 2003). There seemed to be a gap between physiotherapists' professional focus and patients' concerns after acute onset of the disability. Patients were insecure about their future integration into society and their previous social contexts, while physiotherapists emphasised physical recovery and focused on patients' current motor activity. This discrepancy undermined patients' opportunities to influence their treatment and to develop shared physiotherapeutic goals (Wressle et al. 1999; Röding et al. 2003; Cott 2004; Wohlin Wottrich et al. 2004). It also resulted in patients' objections to one-size-fits-all rehabilitation programmes that did not take their individual strengths into account, nor prepare them for real life in the real world (Röding et al. 2003; Cott 2004). When comparing a standard rehabilitation intervention in older adults with chronic diseases with a group-mediated cognitive behavioral counselling intervention focusing on teaching self-regulatory skills, Rejeski et al. (2003) found the latter intervention more effective in sustaining independent, long-term physical activity at home. On the other hand, Pyöriä et al. (2007) found that a rehabilitation intervention which supported stroke patients' own decision-making and active participation in problem-solving and task-centred training was more effective than traditional physiotherapy in enhancing these patients' cognitive and physical functional recovery, and in supporting their return to independent life at home. In stroke physiotherapy, by a traditional intervention is meant the exclusive use of verbal and manual techniques with limited opportunities for active patient participation in setting targets or methods (Talvitie and Reunanen 2002).

Difficulties in integrating active patient participation into physiotherapy treatment sessions have further been confirmed by observations made on video-recorded therapy encounters (Talvitie and Reunanen 2002; Parry 2004a; Talvitie and Pyöriä 2006). Talvitie (Talvitie and Reunanen 2002; Talvitie and Pyöriä 2006) found that physiotherapists rarely discussed the goals of the therapy or any particular exercises with their patients, and in those cases where patients were involved their participation and contribution were limited by the physiotherapist. This is supported by Parry (2004a), who identified eight goal-setting episodes from a total of 74 video recorded physiotherapy sessions. In all but one, the physiotherapists suggested the target problems for which goals were subsequently set. She found that various interactional difficulties and delays occurred when attempts were made to obtain the patient's perspectives and integrate them into the agreed goals. Consequently, Parry (2004a, 2004b and 2005) argued that eliciting patients' perspectives during the therapy intervention is a challenging task because of several constraints on interaction, such as inequalities of knowledge, exposure of one's physical incapability and doubts about the potential for rehabilitation. Thus, not only joint goal setting but also active patient participation during exercises is a challenging task in physiotherapy.

Martin (2004) explored interactional indications of patients' learning during their exercise training. She found that physiotherapists were in charge of the activities until patients gradually gained more skills and confidence in their abilities to perform the exercises. In the initial stage, a learning task was introduced by the physiotherapist and through demonstrations, questioning and negotiations, a shared understanding was achieved. In the second stage of learning, the physiotherapists detected and corrected the performances of patients whose participation in this problem solving was dependent on the physiotherapists. Gradually, patients displayed the understanding and skills required to participate by correcting their performance when reminded to do so by the physiotherapists. In the final stage, patients demonstrated learning by detecting the problem in their performance and correcting it themselves without prompting or assistance from the physiotherapists. She concluded that patients' learning can be described in interaction as an organised, gradual transfer of responsibilities from the other, such as the physiotherapists, to the self, such as the learning patient.

Another aspect of exercise performances was raised by Talvitie and Pyöriä (2006), who studied counselling sessions in which physiotherapists and patients with stroke and their caregivers discussed the patient's postural control and balance problems. The physiotherapists focused on evaluation of the exercise performance of the patients and finding exercises appropriate for practice at home, whereas the patients and their caregivers expressed concerns in relation to difficulties with daily tasks at home. The researchers concluded that, while counselling has great potential to enhance the active participation of patients in their treatment, physiotherapists need to recognize the communication problems caused by stroke and allow patients to participate more actively, and also to ensure to that discussions are more firmly anchored in the patients' social life.

Finally, Iversen et al. (2008) discovered that the processes of communication in physiotherapy treatments of children with cerebral palsy were not smooth and linear, but could be characterized by terms such as discontinuity, transitions and instability. They found both divergent and convergent communicative states, which fluctuated within sessions as well as over time. The three main constraints that seemed to accelerate the occurrence of communicative variability and divergence were complex tasks demanding attention or motor performance, negative changes in patient condition over sessions and when participants did not perceive tasks as meaningful. In contrast, shared understanding and sense of meaning seemed to make it easier for the participants to attend thoroughly and take part in therapeutic activity. As a result, quality of movement was positively affected.

Obviously, inpatient geriatric rehabilitation with its particular professional mandates and physical environments constructs a particular context for the physiotherapy of older adults. However, the activity and range of opportunities for participants will be shaped by the range of both professional practices and patient behaviours. Therefore, it is important to identify how the practice of physiotherapy is constructed in the

group-based geriatric inpatient rehabilitation aimed at frail community-dwelling older adults.

3 AIMS OF THE STUDY

The purpose of this study was to examine the situated praxis of group-based physiotherapy in geriatric inpatient rehabilitation aimed at frail community-dwelling older adults. More specifically, this study investigated older adults' perspectives on physiotherapy by asking what kinds of meanings they attributed to their rehabilitation experience and observing what was their contribution to the interaction in the praxis of group sessions. The study also explored how physiotherapists talked about and performed their professional practice during their situated interaction with older adults during group exercise sessions.

The specific aims of the study were to:

1. Identify the meanings that older adults attribute to their geriatric rehabilitation experiences. (Study I)
2. Investigate how physiotherapists talk about older adults as their clients in geriatric inpatient rehabilitation. (Study II)
3. Examine how professional physiotherapists and frail community-dwelling older adults as their clients use talk and action to construct a group exercise session in an inpatient rehabilitation setting. (Study III)
4. Examine how older people construct their interaction during encounters with rehabilitation professionals in exercise sessions and what is their contribution to the interaction. (Study IV)

4 METHODS

4.1 Theoretical frame of reference

The theoretical frame of reference adopted in this study is social constructionism (Burr 2003). Inquiry embedded in social constructionism focuses on people's descriptions, explanations and accounts of the world as products of historically situated interchanges among people (Gergen 2003, 15). It has its roots in the sociology of knowledge, as discussed in Berger and Luckmann's (1966) seminal book 'The Social Construction of Reality', as well as in social psychology in Gergen's (1973, 1985 and 1997) work. Berger and Luckmann (1966) proposed that although people perceive that their world is predetermined, it is socially constructed by a whole range of different social arrangements and practices. Gergen (1985) also emphasised interaction and suggested that the process of understanding should be treated as an active, joint construction of people when in interaction with each other. He considered these forms of negotiated understandings to be crucial in social life since they are integrated with many other activities and in fact, constitute social action. This implies that in the present study the accounts given in the interviews by physiotherapists and older people about rehabilitation are both descriptions of the events and part of the event due to the constitutive nature of talk (Burr 2003). Furthermore, the interview situations themselves constituted a particular context of interaction, i.e. that of a research interview where the researcher and interviewee jointly constructed the social action at hand (Hepburn and Wiggins 2007). This also pertains to the video-recorded group sessions, in that participants constructed their interaction jointly in the particular context of an exercise class in a rehabilitation facility.

In order to capture the special features of naturally occurring interaction between the older people and the physiotherapists an ethnomethodological approach was utilised in the analysis of the videotaped data. This meant exploring naturally occurring interaction in order to describe the methods people use in doing social life (Sacks 1992, 21); that is, any social occasion is taken as specific, situated and skilful practice in which the participants construct the event, making it understandable and accountable (Garfinkel 1967). The approach was developed in sociology by Garfinkel (1967; Heritage 1984), who focused on 'everyday activities as members' method for making those same activities visibly-rational-and-reportable-for-all-practical-purposes, i.e., "accountable", as organizations of commonplace everyday activities' (p. vii). He proposed that the context of each agent is situated and changes moment by moment along with these situated activities. This implies that each successive action is in relation to the situated context and thus, is context-shaped. Both the embodied comment on the situation and interacting with it is context-renewing. In addition, each social action in these situated practices is inevitably considered accountable (Heritage 1984). Furthermore, each actual interaction is approached in an unmotivated way without preconceptions about the possible occurrences (Sacks 1992). This implied that the institutional setting in which the interaction was occurring in the present study did not, however, predetermine its features as institutional or as confirming to specific normative rules, but instead focused on located practical actions and utterances (Garfinkel 1967). The

meaningful features of each action were embodied in the practical action itself and in the evolving interaction of its participants (Heritage 1984).

4.2 Setting and participants

This study is part of the AGE study, a study of the effectiveness of geriatric inpatient rehabilitation for older adults' independent living at home, which started in 2002 and was initiated by the Social Insurance Institution of Finland. In the AGE study, frail community-dwelling older people (65 +) with unstable health and a high risk of institutionalization were randomised either to a network-based inpatient rehabilitation intervention (n = 343) or to a control group (n = 365) receiving normal social and health care services. The exclusion criteria were: diseases contra-indicating participation in the rehabilitation process, severely decreased cognitive capacity (established by a Mini Mental-State Examination score of less than 18 points), and participation in other inpatient rehabilitation during the preceding five years. (Hinkka et al. 2006.)

The intervention, consisting of three separate in-patient periods within the span of eight months, was carried out by multidisciplinary teams at seven rehabilitation centres throughout Finland. A home visit by a physiotherapist or occupational therapist from the rehabilitation centre took place between the first and second inpatient periods. The rehabilitation programme consisted of group and individual physical exercises, group discussions and health promotion activities in the areas of physical activity, self-care and nutrition. The focus was on promoting the active participation and autonomy of the older people. (Hinkka et al. 2006.) Each rehabilitation group had eight participants, who came from the same municipality, and the groups were kept together throughout the process. The amount of group activities during the inpatient rehabilitation periods varied between three and four hours per day. For the most part the group activities focused on physical activation. The physical activation sessions consisted of exercising indoors or walking outdoors with integrated dissemination of information and educational aspects. (Ollonqvist et al. 2007.)

Of the 44 rehabilitation groups arranged in 2002, a purposive sample of 14 groups was chosen for the study, two from each of the seven rehabilitation centres. The groups were chosen to represent diverse geographical locations and cover both rural and urban areas. In the present study the participants were both the rehabilitation professionals and the clients. The study design, including sampling procedure, is presented in Figure 1 (p. 26).

All the physiotherapists (n = 11) in charge of planning and carrying out the geriatric rehabilitation in the AGE study were approached, and they agreed to participate in the study. The characteristics of the physiotherapists are presented in Table 1 (p. 26). Four of the physiotherapists worked exlusively with clients aged 65 years and older, while the others had a mixed case load.

Figure 1. *Design of the study.*

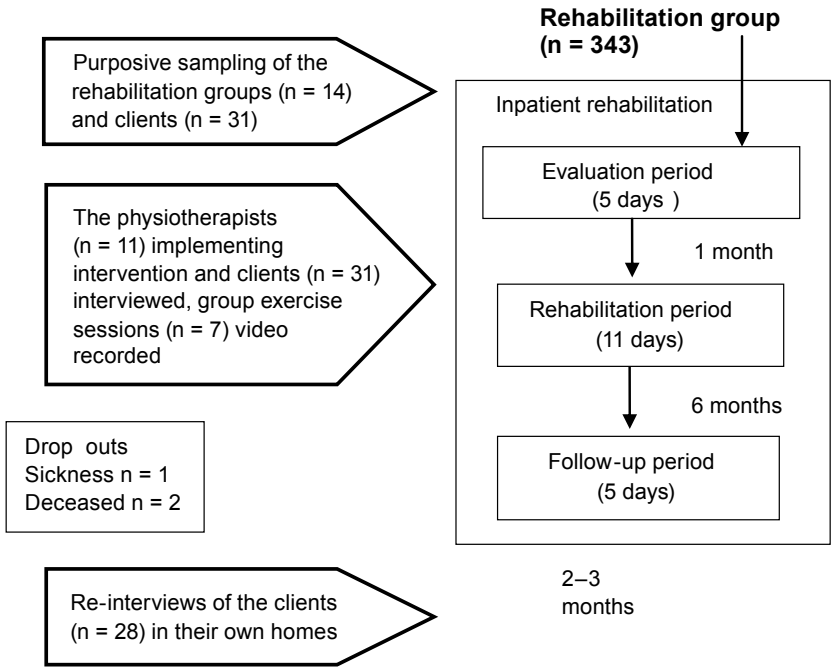

Table 1. *Characteristics of the physiotherapists interviewed.*

Characteristic	Number (n = 11)
Gender	
– Male	0
– Female	11
Age (years)	
– 25–35	3
– 36–45	5
– 46–50	3
Educational background	
– Physiotherapist	8
– Specialised physiotherapist	3
Work experience as physiotherapist	
– 1–3 years	4
– 8–10 years	2
– 14–19 years	5
Continued education in physiotherapy[a]	
– None	4
– Courses on different therapy methods (Bobath etc.)	7
– Courses on geriatric rehabilitation	4
– Basic university studies (in physiotherapy, gerontology, rehabilitation etc.)	4

[a] The number of physiotherapists in this section does not total 11 because of their participation in more than one type of further education.

Of the 14 rehabilitation groups, 7 groups were selected for video recording. The physiotherapists in charge of these seven groups were asked to choose one physical activity group session for video recording during the inpatient intervention. In the video-recorded exercise sessions nine professionals were involved, all of whom were females. Seven of them were physiotherapists and in charge of the session, one was an occupational therapist and one an exercise counsellor. Both the latter were involved in instructing the clients. Work experience among the professionals ranged from one to over 20 years. A total of 52 older adults, comprising seven men and 45 women and ranging from 66 to 93 years of age, participated in the videotaped group exercise sessions. All were independent in mobility with or without assistive devices.

From among the 14 rehabilitation groups, a purposive sample of 31 clients was chosen for interview. That is, four or five participants were selected from each centre to represent diverse geographic locations, different age groups and varying backgrounds. The characteristics of the older adults are presented in Table 2. The participating older

Table 2. *Characteristics of the participants.*

Variable	Category	N t_1	N t_2
Gender			
	Female	15	15
	Male	12	12
Age group (years)			
	66–69	6	6
	70–79	9	9
	80–89	11	11
	90+	1	1
Living arrangements[a]			
	Alone	21	22
	With spouse	5	4
	With adult children	1	1
Location			
	Town	13	13
	Suburban	6	6
	Rural	8	8
Physical activity[b]			
	Inactive	1	2
	Light daily chores	7	9
	House cleaning/light exercise 2–4 hours	12	11
	Moderate exercise 1–2 hours	6	4
	Heavy exercise several times	1	1
Totals		27	27

Notes:
[a] One participant was widowed in-between the interviews; the re-interview numbers in the line t_2.
[b] The physical activity levels are each week and have been modified according to Grimby (1986). Physical activity levels changed in-between the interviews; the number of participants in each activity level at the time of the re-interview is given in the line t_2.

adults were aged between 66 and 93 years (mean 77.6 years). All but one male participant reported one to four chronic diseases that caused functional limitations, including musculoskeletal disorders, cardiovascular diseases, pulmonary diseases, cognitive impairments, visual impairments and mental disorders. Moreover, functional limitations forced all the participants to rely to some degree on assistance to be able to live at home. Such assistance varied from the provision of transportation to help with personal hygiene. In 2003, after the rehabilitation programme, 28 of the older adults were interviewed for a second time. One participant had in the meanwhile been admitted to an acute hospital in a critical condition and two had died.

4.3 Data collection

The study was approved by the ethical committees of the Social Insurance Institution of Finland (SII) and Turku University Hospital. Permissions for interviews and video recordings were obtained from the management of the rehabilitation centres. The topical guides for the qualitative interviews were constructed and piloted with one physiotherapist and two older adults participating in geriatric inpatient rehabilitation.

Before being interviewed the physiotherapists were given a verbal explanation of the study and assurance of confidentiality and anonymity. In turn the physiotherapists gave their verbal informed consent to participation in the study. The semi-structured interviews (Kvale 1996) with the physiotherapists (n = 11) were carried out by the researcher during May through August, 2002. Each interview took place in the middle of the second inpatient period (11 days). The topics discussed in the interviews covered the practical actions of the physiotherapists during their encounters with older people in the AGE study, including how they formulated treatment goals and therapy during the physiotherapy intervention. The physiotherapists were also asked to elaborate on the meaning of the inpatient geriatric rehabilitation intervention to older adults as the physiotherapists understood it. The interviews were conducted at the rehabilitation centres during the physiotherapists' regular working hours, and each interview session lasted from 20 to 50 minutes. The interviews were audio-recorded and transcribed for analysis.

The older adults chosen for the interviews were initially approached with a letter explaining the purpose of the study and the voluntary nature of their participation. All who received the letter agreed to participate. Before the interviews a detailed explanation was provided and confidentiality was assured, and the clients gave their informed consent in writing. The interviews for the clients (n = 31) were conducted in the rehabilitation centres during the last week of their second inpatient period, in 2002. The topics of the first semi-structured interview were the following: everyday living at home, previous and current physical activity (work activities, household chores, leisure activities, exercise), experiences of the rehabilitation intervention, goal-setting and the purpose of the inpatient rehabilitation program at the rehabilitation centre. The interviews were carried out by the researcher and audio-recorded; they

lasted from 20 to 60 minutes. Immediately after the session, short diary notes were made for later use. The second interview took place at each participant's home two to three months after the third inpatient period, i.e. six months after the first interview. Before conducting the re-interviews a verbal informed consent was obtained from each participant. The second, semi-structured interview covered the following topics: everyday life at home after the rehabilitation, the exercise programme at the rehabilitation centre, exercising at home, and coping at home in the future. The interviews lasted from 45 to 150 minutes, with an average duration of 1.5 hours. Immediately after each interview, a diary was completed covering such issues as the home environment and the atmosphere of the interview.

During the interviews the topical guides were loosely followed and the older adults allowed to talk freely, even if their chosen topic was not related to their rehabilitation experience or daily living at home. Some participants confide in the researcher and their stories were emotional and private. On these occasions the older adults were given opportunities to change the topic to a more general one. In addition, after these interviews the participants were asked whether they would leave the tape with the researcher for research purposes. In general after each interview the older adults were given an opportunity to ask questions or talk without the tape recorder about any topic they wished to discuss with the researcher.

The video recordings took place during 2002, and were carried out in the middle of the second inpatient period at each centre. Physiotherapists from each rehabilitation centre were requested to choose one group session for video recording during the inpatient intervention, but no instructions concerning the implementation of exercises were given. Before the video recordings the study and the voluntary nature of participation in it were explained to the clients. All of the clients agreed to participate and gave their written informed consent. The videotaped group sessions lasted approximately 45 minutes and were carried out in a gym, with one exception of an outdoor exercise session. In four sessions, the older adults were seated in a semi-circular or in a row facing the instructor, who was either standing or sitting. In three sessions, the older adults were scattered around the gym, either sitting or standing at different exercise sites or machines. The instructor moved between them, providing them with verbal cuing and hands-on assistance. During the actual recording, the camera was stationary in order to obtain consistent coverage of the scene, and a supplementary microphone was used together with a small-size tape recorder attached to the physiotherapist. The researcher stayed behind the camera, observing and recording the session.

4.4 Data analysis

The data from the client interviews (Study I) were analysed by the application of an inductive qualitative method (Dey 1993; Kvale 1996). The preliminary analysis was done during the interviews by the researcher who condensed and interpreted the meaning of the interviewee's responses, by making a verbal summary and discussing it with

the participant. The tape-recorded interviews were transcribed verbatim. Then, each interview was listened to by the researcher, who consulted the interview diary and noted any affective behaviour, such as crying or laughing. The transcripts of the first and second interviews with a participant were processed together to gain understanding of the changes and processes that the person reported during the two interviews. After gaining familiarity with the transcripts, the researcher inductively identified the key issues and themes relevant to the research question. The data from each interview were then coded. This entailed reading the subjects' answers while bearing in mind the context, and coding the statements from the participants' viewpoint as understood by the researcher. The imputed meanings were noted besides each coded sentence. Each interview and re-interview were summarised in a one-page account of the themes and meanings expressed by the interviewed person. The next step was to categorise the meanings with reference to the research question. The brief descriptions of the accounts given by the 27 individuals were re-read and three categories identified, initially by the first author. Validity was examined through triangulation, all the authors discussing and agreeing on the final categories. The range of each category was defined making comparison of the three identified dimensions possible. Again, the data were summarised as a whole, and associations and patterns across the categories noted.

The analysis of the interviews with the physiotherapists (Study II) was carried out applying discourse analysis (Edwards and Potter 2001; Potter and Wetherell 1987). The premises of this approach derive from social constructionism, implying that language is used by people to do things. Language use has several different functions, such as talk is rhetorical by designed to counter potential alternative versions, and has also several different consequences. Thus, discourses are considered action-oriented. Discourses are also situated, implying that talk is embedded in sequence of interaction in different kinds of everyday and institutional activity. Language is therefore simultaneously both constructed and constructive. Thus, analysing the construction of different versions makes it possible to the researcher to consider the practices those versions are part of, and the particular work they are performing (Potter and Wetherell 1987; Edwards and Potter 2001). These principles were adopted in the analysis of the physiotherapists' talk about their work with older adults in that descriptions were not approached as reflecting their internal stereotypes or attitudes, but in line with Potter and Wetherell (1987), were assumed to be constructed to accomplish particular actions, such as providing factual accounts of mundane work practices, and also to have consequences by creating certain types of categorisations or versions of reality.

The analysis started with the first author seeking to obtain an overall understanding of the material by reading the transcribed interviews several times. During this phase, the physiotherapy descriptions showed wide variation, which seemed to warrant closer examination. After familiarisation with the data had been gained, text units relevant to the research question were identified. These text units pertained to the physiotherapists' talk about their clients in relation to the practical actions during encounters. The meanings of the units were identified and then labelled by the first author. By meanings is meant the positioning of the older adults constructed in the

descriptions given by the physiotherapists, such as disengaged and passive, diseased, or active. The positioning was compared and contrasted with the original transcriptions in order to explore whether it was connected with any specific definitions of the aims and contents of physiotherapy. Any such definitions were further explored for their different dimensions in relation to the positioning of clients. The meanings and their dimensions were explored both thematically and by case in order to assure the saturation of each account. The meanings were discussed with the co-authors, referring to the original transcripts. Finally, two accounts emerged. The co-authors reviewed the accounts in order to validate them.

The video data (Studies III and IV) were analysed utilising discourse analysis (Potter 1996 and 2004; Edwards and Potter 2001) where the focus was on the micro-level of naturally occurring interaction in order to explore how the social practice of group exercise sessions in geriatric rehabilitation is constituted. The recordings of natural interactions during group sessions enabled analysis of sequentially occasioned, situationally oriented and rhetorically designed discourse. This applied not only to discourse but also to non-verbal actions, in line with Scollon (2001) and Heath's (2004) notion of the utilisation of embodied actions, gestures and physical objects to mediate meanings (Edwards and Potter 2001). The analysis of the group exercise data involved close inspection of the videos and the writing of descriptive logs of each video by the first author. The data analysis sessions were carried out jointly by the co-authors. Verbal activity was transcribed according to a simplified version of the Jefferson convention (Atkinson and Heritage, 1984), illustrated in the Appendix 1, and non-verbal activity, for example, body positions, gazes, gestures was annotated. The extracts that are presented in the original papers were translated into English by a native English-speaking translator, as literally as possible from the original Finnish transcripts, which are provided in Appendix 2. Interactional occurrences (e.g. clients' questions) in each video were systematically collected in order to scan the whole of the data inclusively for their frequency. This was done to ensure the inclusion of all apparently typical and deviating cases. A detailed analysis then followed to identify patterns of consistency and variability, and the functions of the interaction. Traces of the institutional features of interaction (Heritage 2004) in particular, were probed, such as the overall structural organisation of the interaction, turn-taking organisation, lexical choices and forms of asymmetry. In the third paper the focus was on the ways the physiotherapists' constructed the group exercise sessions. This related to a variety of aspects, such as presenting and maintaining the agenda and organizing the physical environment of the sessions, verbal and non-verbal activities of the physiotherapists during sessions, and interaction between the physiotherapists and clients during group sessions. The analytical focus of the fourth paper stemmed from the above described analyses and the focus was on older people and their interaction with each other and with the professionals during the group exercise sessions. In comparison to the previous analysis, i.e. study III more detailed attention was paid to clients' verbal and non-verbal initiations and how these were received by the physiotherapist. Furthermore, attention was focused on the positions negotiated between the clients and the professionals during the situated actions.

4.5 Quality issues

Validation of the research findings in this study refers to the dialogical and on-going process of intersubjective agreement (Angen 2000), reflecting the theoretical assumptions adopted in the study. Drawing on the assumptions of social constructionism (Gergen 1985; Potter 1996), knowledge, and in this case also scientific knowledge, is produced in historically and culturally contextual and situated interactions, where its members are treated as accountable for their actions. This implies moral responsibility in all dealings, since people do not live in the world as if nothing mattered; rather interaction between people and things is continuously meaningful owing to the making of practical and ethical choices about actions and interactions (Angen 2000).

The triangulation of the data, which was built into the research process from the outset, was utilised in line with Seale's (1999) notion of gaining multiple perspectives on the realities of rehabilitation. This meant approaching different data sets with different research questions and methods of analysis and also reporting the results in separate papers. This process was time-consuming and laborious, and also yielded diverse findings. Sim and Sharp (1998) discuss this divergence as challenge to triangulation, which was taken up, however, following Angen (2000) and Seale (2002) as an opportunity to gain increased understanding of the multiple realities in interplay during rehabilitation.

An audit trail of the research process of this study was implemented in line with Angen's (2000) view of validation in interpretive research as a process of intersubjective confirmation of pragmatically and morally trustworthy findings. Koch (1994) discussed a decision trail in relation to establishing rigour in qualitative research, drawing on the constructionistic paradigm. A decision trail stems from the idea of fiscal audit, where the auditor examines the process of account keeping and gives an assurance as to its dependability. She described establishing an audit trail through writing a detailed field journal during the data generation process of her own interview study (Wohlin Wottrich et al. 2004). Horsburgh (2003) suggests an even more comprehensive audit process incorporating a clear explication of the theoretical, methodological and analytical decisions made throughout the study. Following this train of thought she mentions the challenge posed by confidentiality issues in the case of direct access to data, such as audio-taped interviews. This comprehensive audit trail concept was utilised throughout the present research process. In order to avoid risk to the anonymity of participants, the audit was performed by the supervisors of this study. During each phase of the study documents and data were viewed and discussed and revisions performed until agreement was reached.

The use of low-inference descriptions or data is another means for enabling readers to be informed about the researcher's interpretations and to be more equipped to evaluate their adequacy (Seale 1999; Silverman 2001). In line with Silverman's (2001) suggestions, every face-to-face interview was tape-recorded and the group sessions both video-recorded and tape-recorded in this study. These tapes and videos were

initially transcribed verbatim. Seale (1999) points out that 'tidying up' the transcriptions, that is removing hesitations, pauses and even dialect, may distort the original meaning of the interaction and that transcription conventions utilised by conversation analysis represent low-inference data in the precise meaning of the term. Following this notion the initial transcriptions of the physiotherapists' interviews and video data were re-transcribed in more detail, applying the transcription conventions of conversation analysis. Furthermore, in the reporting phase long extracts from the data were presented in line with Silverman's (2001) recommendation.

Comprehensive treatment in this study applied not only to transcribing the whole data set, but also fully reading through, followed by coding and analysing, every interview and each group session according to Silverman's (2001) suggestion. This comprehensiveness also involved looking for exceptions or contradictory accounts or 'deviant cases' in the data (Potter and Wetherell 1987; Seale 1999; Silverman 2001). In this study these instances were not considered negative or deviant in the traditional sense of conflicting with a hypothesis, but rather illuminating the great variety of accounts or possible actions in the data. Including these less typical occurrences in the analysis further facilitated the process of clarifying the boundaries of the emerging categories to assure their inclusiveness but also to avoid overlapping categorisations. Thus, exceptions facilitated modifications of the researcher's emerging ideas, as described by Peräkylä (2004) with reference to Clayman and Maynard (1994). He describes another use for deviant cases or exceptional accounts in research, which was used in this study, that is, providing additional support for the analyst's conclusions by demonstrating participants' acknowledgement of an unusual event. Paying close attention in analysis to what the participants themselves see as consistent or different, is termed "participants' orientation" in discourse analysis or "members' method" in conversation analysis (Potter and Wetherell 1987; Drew and Heritage 1992) and is important in validating the findings of naturally occurring interactions. A detailed analysis of participants' turns in the situated encounters of this study was utilised to reveal their intersubjectivity, that is, shared meanings amongst the participants. An example from the video data will serve to illustrate this method. During one episode in a gym a client asked the physiotherapist a question, but received no answer, even after repeated attempts. In order to analyse what was going on in the episode, close attention was paid to the unfolding interaction turn by turn utilising the conversation analysis concept of adjacency pair organisation (Goodwin and Heritage 1990). This implies that 'first pair part' action of a question requires a 'second pair part' reciprocal action at the first possible opportunity. When this appropriate next action is not forthcoming, it is normally acknowledged by the person who initiated the question, thus keeping the other participant accountable for his or her action. This approached yielded more detailed understanding of the organisation of action and participants' understanding in interaction.

5 FINDINGS

5.1 Older people's "voices" (Study I)

Three categories of the meaning of rehabilitation were inductively formed from the analysis of the interviews with the older people: sense of confidence with everyday life, sense of vacation and sense of disappointment in the rehabilitation programme. The findings showed that the participants' perceived needs and their expectations of rehabilitation varied. Some talked about spending time in a spa, while others searched for solutions to the challenges that they faced in their daily lives at home and expected intensive physical training and treatments.

The category named 'sense of confidence with everyday life' comprised expressions by the participants concerning the various benefits that they derived from the rehabilitation. These older adults constructed a coherent story, and described incidents in their lives that were challenging or caused problems. They felt that the rehabilitation intervention would help them cope at home in a practical way, the following extract illustrates:

> Q: Whose idea was this that you practised these kinds of things? A: Well it was getting out of a chair, this was what they were teaching us. We used a higher chair and then next a lower one – –and then I said that I'll fall over and I won't be able to get up. And then we started talking, and they asked me, 'Should we practise this?' and I said 'absolutely'. And then we tried it, several times, and every day it went better and better. It really helped build up your confidence (to the point that I) can get up.

The perceived benefits were interwoven with the sense of being able to take care of oneself owing to increased confidence in one's own abilities and resources and of being able to cope with everyday life due to the availability of assistive devices and home visitors, with improved exercise-induced physical abilities that moderated hindering symptoms and increased functional abilities, and with satisfaction with encouraging interaction with the staff due to getting one's own voices heard and receiving individualised care.

The category named 'sense of vacation' contained expressions by the participants' that referred to the three stays in the rehabilitation centre as a vacation or pleasant break from duties and responsibilities at home and to the rehabilitation centre as a spa or resort. In the accounts the rehabilitation experience was contrasted with the everyday life at home. This 'sense of vacation' was manifested in expressions referring to carefree living, enjoyment and pleasant social interactions. The aspects of carefree living and enjoyment were intervowen with speech about receiving good care and being served and recognised. This feeling of being cared of was attributed to enjoyable spa treatments, a ready-made activity schedule for each day and abundant meals. Another important aspect of a meaningful rehabilitation experience was the social participation derived from group-based activities. A 'sense of vacation' was emphasised in the participants' accounts after the intervention, the rehabilitation episode having became a happy

memory, a vacation from everyday living and a source of raised spirits, although this pleasurable feeling did not last long, as following extract illustrated:

> A: Well it was pretty good – I said it was – was that time round. I noticed it when they said to me when I came (back home) that you're much more energetic. I said just think about it – all you had to do was sit down at the table – you didn't have to worry about anything. They looked after everything. And you could still (laughs) fool around – do whatever you could. I said, but now I'm beginning to slip back to the same shape I was in to start with. So it didn't help me for very long, but – (sighs) it really was good.

During the re-interviews, the participants contrasted their enjoyment of the rehabilitation centre with their lonely or challenging everyday life at home.

The category named 'sense of disappointment' consisted of expressions by the participants of their dissatisfaction with the rehabilitation programme, most commonly that it was inflexible and not individualised. These participants articulated their needs and described how they went to the rehabilitation facility with great expectations but experienced frustration over the programme, which appeared to them to be pre-set to a certain format and lacking in opportunities for client participation in its planning or goal setting. This group of participants perceived the content of the rehabilitation programme as maladapted for their needs, as illustrated in the following extract:

> A: (The) standards varied quite widely in our group, I mean, myself, I'm sure I would need to have a slightly tougher programme. So, in that sense, I should have been in a slightly, slightly different group. Others have much more difficulty with their mobility, we're not all equal in that sense. Q: Do you feel this was taken into account in your group? A: No it wasn't, it wasn't been taken into account in any of the indoor activities, but outdoors, there I took rather longer walks than the others who needed to use a walker.

For some participants the sense of maladaptation stemmed from their expectations of a programme scheduled with less free time, and that was more exercise-oriented less based on lectures and conversations. Moreover, they had expected more vigorous physical activity. For some frail participants who used assistive devices the sense of maladaptation had an opposite origin: they were unable to adjust to the schedule of activities, which they found hectic. Having to participate in different activities throughout the day and being unable to rest for a while was found too demanding. Overall, these participants perceived the rehabilitation as having no affect on or changing their daily life at home.

5.2 Physiotherapists' accounts (Study II)

Two accounts emerged from the interviews data of the physiotherapists: older adults as recipients of a treatment intervention at the rehabilitation centre, and older adults as partners in an exercise intervention to support their everyday lives at home. The first account was found to have two dimensions, which were 'a focus on physical impairments' and 'a focus on social needs'.

In the account of older adults as recipients of a treatment intervention at the rehabilitation centre, the physiotherapists' talk about the therapy encounters reflected a 'one-way' flow of interaction. The physiotherapists described physiotherapeutic assessments, and information and treatments as being delivered from professionals to clients, thus, positioning themselves as active performers and their clients as more or less passive recipients. In the dimension 'a focus on physical impairments', the physiotherapist constructed the client as a mechanical entity with isolated dysfunctions, such as limited joint movements or muscle weakness in the extremities, which can be clinically assessed and treated, as illustrated in the following extract:

> PT3: Well, from the measurements, for example, we see what their needs are. If they have lots of problems with joint movements, we'll use "range of motion" exercises and start from there. If they have muscle weakness in the lower extremities we'll start exercising that. If there are problems with balance, we'll start exercising that.

The position constructed for older clients was as the object of assessment and recipient of treatment chosen by the physiotherapist. In the dimension 'a focus on social needs', the descriptions of the physiotherapists centred on the perceived passivity and reluctance of older clients. In the physiotherapists' descriptions some older adults were portrayed as solely desiring to be cared for, nurtured and pampered, and in these cases the physiotherapists described adapting the rehabilitation programme to meet their needs, justifying this approach by reference to patient-centred values, as illustrated in the following extract:

> PT 4: So I mean if you think of physiotherapy and whatever, I mean there's that as well. But there's a lot more, listening and cuddling and such-like. I mean we could provide a lot more of these fancy plans and fancy movements and everything else. But that's not something that comes from the client and this kind of rehabilitation wouldn't be customer-oriented.

Thus older people were constructed as passive recipients of comfort treatments with emphasis on the clients' desire to be passive recipients.

In the account of older adults as partners in an exercise intervention to support their everyday living at home, the physiotherapists' talk reflected a 'two-way' flow of interaction. The clients were described as active agents in their lives, and thus were actively involved in the assessment of their needs and the negotiation of their treatment goals

with the physiotherapist. In this account, the physiotherapists postulated that functional capacity alone did not reveal how an older individual manages everyday tasks at home. The daily tasks and the physical living environment needed to be considered as well. Emphasis was placed on the individual's own resources and strengths. The physiotherapists described the participants themselves as the experts on their lives and on the challenges therein. Thus, physiotherapeutic problems were analysed jointly by the participant and physiotherapist, as shown by the following extract:

> PT 1: It's very much a matter of talking and chatting, at least I try to get to know this person in their own home. You know, how does this elderly person spend her days? And then of course by observation, by interviewing and to some extent by taking measurements, the aim is to find out at the same time what kind of resources this client has, how much strength, what are the risks of having a fall, what kind of joint mobility do we have, how much pain is there, we find out all of this at the same time. And then I try to work out together with the patient the areas, the critical points we should concentrate on, and what the biggest threats in the future are like if things go downhill and they can no longer cope on their own at home.

The physiotherapists described their aim as enhancing older adults' ability to live in their homes by introducing simple but effective functional exercises. The rationale for the intervention was described by the physiotherapists as learning through repeated and reasoned training; the participants would gain practical tools to maintain their functional capacity back at home.

5.3 Constructing group exercise sessions (Study III)

The construction of group exercise classes was a multidimensional activity consisting of deciding on the physical environment, physical actions and discursive practices of the participants. The physiotherapists constructed group exercise sessions in three distinct ways, and each approach demonstrating a different pattern of interaction between client and professional. All three approaches represented 'physiotherapist-initiated exercises', meaning that the dominant form of interaction or communication comprised generalised exercise instructions delivered by the physiotherapist to the group of older adults, who then responded by performing the exercises. The physiotherapists initiated all the activities, and did most of the talking. The participants orientated collaboratively to this dominant format and aligned themselves as instructor and instructed.

In the structured exercise sessions, the physiotherapists constructed encounter in a highly orderly manner. The distinguishing characteristic of the structured exercise sessions was that the physiotherapists provided an almost unceasing flow of exercise instructions combined with model performances of the movements. This is illustrated by the following extract, which is taken from the middle part of a warm-down with relaxing prolonged stretching.

1 PT: – – Turn round so that your left (.) hand reaches up to the wall and (4)
2 I: I'm not getting to the wall.
3 PT: on the rungs (.) And now that hand is at the level of the (1) shoulder (.) fingers
4 pointing backwards (2) And take a peek over the right shoulder backwards – –

There were occasional tag and exam questions to solicit verbal input from the clients, but generally speaking, the clients were assumed to concentrate on performing the movements according the instructions, thus providing physical response and participation in the sessions. The exercises were easy to perform, low in intensity, and did not demand any special skills. The music was played at a loud volume, and the clients were positioned close to each other. They participated enthusiastically in the these activities.

In the guided exercise sessions, the physiotherapists constructed the encounters in a less structured manner. Although every client simultaneously performed the movements according to the generalised instructions, the distinguishing characteristic of these sessions was that the physiotherapists were also able to provide individualised guidance in the form of verbal and tactile cuing. The rationale given was that during guided sessions the clients would learn to perform the exercises, and would then be able to continue exercising independently at home. Consequently, the physiotherapists provided feedback to the clients to enhance their motor learning. This is illustrated by the following extract, which is taken from the middle of a collective review of a home exercise programme where the exercise in question is standing on one leg.

1 PT: Right (.) So let's now try the weaker leg (.) or is its weaker let's see (.)
2 First of all your legs one after the other and weight on both legs to begin with (.) try
3 to find a sort of comfortable balance (.) and then very slowly move your weight
4 forward and only lift the trailing foot up in the air (.) Anna keep the whole of your
5 other foot ((guides Anna's posture manually)) on the floor and your body
6 completely straight (.) From there you start lifting (.) try that now (.) with your
7 trailing foot rising slightly up.
8 A: It's not rising?
9 PT: No (.) your toes are still touching the floor.
10 A: Oh completely.
11 PT: Yes completely.
12 A: I thought the heel.
13 PT: No no (.) your toes off the floor (.) as well.
– – two lines omitted where other clients report their success in the exercise.
14 PT: Good (.) that's right (.) good and then shake your legs again a little (.) And
15 then you can sit down again on the stool and catch a little breather.
16 A: I thought we were only supposed to lift the heel.

17 PT: Mm-m (.) I wonder whether you're going to have to do your homework all
18 over?
19 A: I'm sure.

The clients and the physiotherapists occasionally co-constructed joint understanding of the importance of exercise as part of daily life. This shared understanding was found when a client initiated talk about her or his daily routines at home, which the physiotherapist pursued further making a link to exercising at home.

In the circuit training sessions, every client had her or his own set of exercise sites with a particular exercise to perform in each, and changing the site after one or two sets. The distinguishing characteristic of the circuit training sessions was that they were less structured, which seemed to allow for greater variety what constituted a successful performance. On the one hand there were clients who remained baffled and insecure, and constantly requested assistance and assurance, while on the other there were clients who attained a sense of mastery over the exercises and demonstrated this by unofficially adopting a peer tutor position. This is illustrated by the following extract, where participants are changing exercise sites in the gym and "Hilkka" provides peer assistance to "Saara" and "Anna".

1 PT: Right (.) Let's start changing again the exercise sites.
2 H: Saara will go to the [bottoms-swivel-site] ((points to the balance cushion))
3 PT: [As soon as Paavo gets first] (.) as soon as Paavo gets safely
4 up. ((goes to assist Paavo in getting up))
5 A: How did you always [just raised your leg?] ((addresses the question to Hilkka))
6 PT: [And now (.) you actually could] (.) ((guides Paavo))
7 H: Just backwards. ((demonstrates the movement to Anna))

Another way of constructing a position of competent exerciser was accomplished by requesting a greater challenge in the proposed exercises, such as heavier weights. The physiotherapists accommodated these client initiations in varying ways ranging from ignoring them to attending to them.

5.4 Clients' contributions to the interaction during group sessions (Study IV)

The discourse categories used by the older people during their encounters with the rehabilitation professionals during exercise sessions formed a spectrum. Four discourse categories were identified in the analysis of the data.

In 'taciturn exercising' the older people received instructions and guidance without or with minimal verbal acknowledgement and participated by performing the physical

exercises. In the group exercise sessions the primary objective was physical activity in variety of forms, thus the preferred activity structure was physiotherapists instructing and clients exercising. This mode of action was collaboratively constructed, as was demonstrated by the participants' orientation to it. This is illustrated by the following extract where a group is sitting on benches in a circle performing warm-up exercises.

1 PT: Good (5) And now let's run like a sprinter (3) GOOD! ((laughs)) A 100-metre sprint
2 (1) Good! (1) Use your opposite hand to tap (.) your knee (1) And every time you lift your
3 knee up and (5) and if you can lift your knee high enough then you can even tap your
4 elbow against your knee.

There were several pauses between the physiotherapist's utterances where the older people could have taken verbal initiative but chose nevertheless to refrain from doing so. The physiotherapist in turn did not solicit any verbal feedback from the clients, and thus the preferred uninterrupted flow of exercise instruction and physical activity was established.

In 'submissive disagreeing' the older adults responded to the physiotherapist's instructions by indicating difficulty, emotions or disagreement, but nevertheless submitted to the professional's judgment of the situation. During the group exercise sessions, there were occasional episodes of dyadic interaction between a client and a physiotherapist, which allowed the client to express disagreement. These displays of misalignment were typically constructed by clients in a subtle way, but there were also episodes of direct opposition to the physiotherapist's agenda with simultaneous, although reluctant, conformity with the physiotherapist's proposals. This is illustrated by the following extract, which is from the middle of a circuit training obstacle course and where "Esteri" is currently sitting on a chair resting from the previous exercises.

1 PT: Then (2) Esteri (1) ((instructor looks at the exercise sites and then turns her eyes back to
2 Esteri)) Esteri is now going to have to ((laughs))
3 E: Whereabouts? ( ) you're not going to come and get me ( )
4 PT: Come here (7) ((takes Esteri by the hand and leads her towards the exercise site, Esteri
5 follows behind her right shoulder)) let's do some beam walking here but you don't have to
6 [get up here] ((points at the ramp))
7 E: [That's not] (.) I was thinking that if I don't get up that=
8 PT: =no you don't have to (.) yeah-
9 h. (.) But (.) let's put a cap on our head straightaway (1) ((instructor bends down

to pick up a
10 frisbee from the ground and places it on Esteri's head)) come here (3) there you are (.)
11 now let's see whether you can keep your cap on ((laughs))
12 E: °No it won't stay there°.
13 PT: °Try° lift your head up a bit (.) let's see what happens when you just take a step like
14 you don't have to look down really you just need to put one foot in front of the other (1)
15 whoops ((laughs as the frisbee falls to the ground and picks it up))

At times the physiotherapists yielded in the face of client opposition and modified the task, while simultaneously maintaining their status as professionals prescribing the activities.

In 'resilient endeavoring' the older people made initiatives and held their ground, regardless of the disapproval of the professionals. During the group exercise sessions in the circuit training format, where each client had their own exercise site with rotation between sites in order to try out each exercise, there were client-initiated episodes of exercise modifications or solicitations for information. These initiations were generally treated as deviations from the standard flow of activities by the physiotherapists, but the older adults held their ground and at times successfully obtained the desired modifications with the physiotherapist's consent. This is illustrated by the following extract, which is taken from the middle of a circuit training session, and where "Eila" initiated a modification of a resistance tube exercise by doubling the tube, owing to having just broken the tube during her previous turn.

1 E: ( ) stronger?
2 PT: No don't put (.) it will hold (.) it was just (.) it's just that the old one it's been there so
3 long that that band has [it was time for it to snap].
4 E: [I'll do two ( )] ((folds the band over))
5 PT: Yes you do that ((laughs)) (.)( ) except that then there's (.) yes well (.) Not too tight (.)
6 yes you (.) like that and then hold your back straight and just pull your elbows [back]
7 E: [I'm] too far back ( ) in the chair.

There were also some occasions where the physiotherapists did not accommodate clients' initiatives but persisted in continuing the activity on their terms. Clients' resilient endeavors were demonstrated in some of these episodes by their reconstructing the situated meaning of the activity.

In 'lay helping' the older people initiated and persisted in providing support for their peers. Displays of peer support were observed in exercise classes in the circuit training

mode. The physiotherapist was unable to provide instructions to everyone in the group at the same time. Moreover, the older people were heterogeneous in their functional abilities. Some clients required constant verbal cuing, but some performed activities independently with confidence. The lack of resources by the physiotherapists to provide assistance and guidance, in combination with competence of some older adults with exercise performance, thus resulted in active lay helping. This lay helping occurred naturally and spontaneously and was always initiated by the older people. This is illustrated by the following extract, which is taken from the middle of the circuit training obstacle course, where "Pauli" recruits assistance from "Aarre" to do the obstacle course and proceeds to the activity regardless of the disapproval of the physiotherapist, who is preoccupied with providing hands–on assistance to another client, "Esteri". A peer, "Laura", attends to the proceedings and provides verbal cues.

1 P: Would you hold (.) would you hold my hand if I do that? ((looks at Aarre and points at the track. Aarre looks at the track and walks over to Pauli, sits down next to him and starts a quiet conversation with him))
– – 13 lines omitted where another client discusses her performance with the physiotherapist
2 PT: Wait (.) I'll come and walk you through = ((speaks to Pauli, who has already got up and is walking towards the track))
3 L: =Aarre (.) go and take Pauli by the hand ((shows Aarre how to take Pauli by the hand)).

Lay helping consisted of encouraging, providing positive feedback, exhortation, but also providing verbal and physical assistance for the exercise performances. The physiotherapists generally allowed this lay helping, but there were occasions where it was disapproved of. The older people, however, persisted in their helping activity.

6 DISCUSSION

This study explored the situated praxis of group-based physiotherapy in geriatric inpatient rehabilitation aimed at frail community-dwelling older adults. Older adults' perspectives on physiotherapy were investigated by asking what kinds of meanings they attributed to their rehabilitation experience. In addition, the study explored how physiotherapists talked about older adults in relation to their work practices in geriatric rehabilitation. In addition, situated interaction between older adults and physiotherapists was observed during group exercise sessions. Finally the study examined how the physiotherapists constructed the group exercise sessions and how the older adults contributed to the interaction in the praxis of these group sessions.

The data showed a rich variety of descriptions, both by the older adults and by the physiotherapists in their accounts of the situated praxis of geriatric inpatient rehabilitation. The older adults attributed a variety of meanings to their rehabilitation experience. These were labelled 'a sense of confidence with everyday life', 'a sense of vacation' and 'sense of disappointment'. The physiotherapists described the older adults, as rehabilitation clients, either as recipients of a treatment intervention at the rehabilitation centre, or as partners in an exercise intervention to support their everyday living at home.

The physiotherapists were also found to utilise rich variety of practices in the construction of group exercise sessions, which in turn shaped the opportunities for interaction. Three distinct ways of constructing group exercises were found: in the structured exercise classes the physiotherapists gave instructions to the clients, who performed the exercises accordingly; in the guided exercise sessions the clients had opportunities for discussion about the exercises and their meanings with the physiotherapists; and in the circuit training sessions the clients had opportunities for individual discussions about the exercises with the physiotherapist and with their peers.

The older people's opportunities for making meaningful contributions to the interaction was both restricted and enabled by these diverse ways of constructing group sessions. Four interactional positions were identified during the exercise sessions. In 'taciturn exercising' the older adults remained verbally silent but physically active. In 'submissive disagreeing' the older adults opposed the physiotherapist's agenda by displaying reluctant consent to proposals. In 'resilient endeavouring' the older people persisted in their course of action, regardless of the disapproval of the physiotherapists. In 'lay helping' older people initiated encouragement by giving verbal and physical assistance to their peers.

6.1 The older adults' and the physiotherapists' accounts of the inpatient rehabilitation

In the first study, it was found that although the older people were asked to describe their rehabilitation experiences, the accounts they provided highlighted the impor-

tance of everyday living at home. In the descriptions of 'a sense of confidence with everyday life' the older people constructed everyday life at home as the point of reference against which they reflected on the meaning of the rehabilitation programme (Study I). The intervention was described as helpful since it was modified according to their individual needs as defined by the challenges they faced in everyday living. Descriptions of disappointment in the category 'a sense of disappointment' stemmed from the same source, supporting the results of previous studies (Röding et al. 2003; Cott 2004) where it has been shown that patients objected to interventions that failed to take into account their individual needs in relation to their everyday living conditions and functional ability. According to these disappointed accounts institutional procedures were given priority over their voiced individual needs. A number of studies have confirmed patient perceptions that even where they explicitly expressed their wish to participate in treatment decisions, they were not allowed to be involved in them a meaningful way (Payton et al.1998; Röding et al. 2003; Wohlin Wottrich et al. 2004).

It has been argued that patients' opportunities for active participation in their own therapy are limited in situations where physiotherapists focus on physical functions and motor activity in isolation from the context where these functions would be required to accomplish everyday tasks (Thornquist 1994b; Jorgensen 2000; Röding et al. 2003). Further, previous studies have pointed to the existence of a gap between patients' concerns over managing in everyday life and the professional focus of physiotherapists on physical function (Thornquist 1994b; Talvitie and Pyöriä 2006). Consequently, in the interview accounts categorised as 'a focus on physical impairments' the physiotherapists described their clinical reasoning which was based on clients' physical impairments (Study II). Objective measurements concerning the physical body and its functions were given priority over other types of information, such as clients' subjective needs. This account, in which the professional was positioned as an active agent performing the problem solving and providing the client with appropriate treatment thus positioning the client as a recipient of the intervention, bore a resemblance with the kinds of professional practices that have been suggested as undermining older people's sense of independence and self-determination (Proot et al. 2000).

The second study also found that the physiotherapists to a considerable extent depicted their older clients as frail, old and lonely home-bound adults in need of comfort and nurture while in rehabilitation. Some older people on the other hand highlighted the vacation-like aspect of the rehabilitation (Study I). They constructed an account of 'a sense of vacation' in which they mentioned taking a fortnight off from home and described all of the aspects of the intervention that caused them pleasure in contrast to their dull everyday lives, rather than conforming to the institutional definitions of a client in need of an intervention. It was not the therapy aspect of rehabilitation that they found attractive, but rather the social interaction and the resort-like facility, confirming previous findings of importance of the social engagement in older people's health and well-being (Hillerås et al. 2000). The physiotherapists however, described this as problematic since the clients were no longer motivated to participate in the

kinds of physical activity or active exercising typically utilised in physiotherapy (Study II). This resembles Becker's (1994) finding that motivation and perseverance are major prerequisites for intensive rehabilitation. In cases where these qualities were absent, the standards and goals of the therapy were lowered accordingly. In the same vein, the physiotherapists in this study described another set of intervention explicitly focused on comfort and enjoyment for these clients. Although providing nurture and physical contact were grounded in patient-centred values and older people's pronounced social needs in the accounts of the physiotherapists, they have been argued to have the deleterious effects of creating increasing dependency (Baltes and Wahl 1992) and lessening the ability of older individuals to live outside of the rehabilitation facility (Hart et al. 2005).

These findings of the first and second studies showed that although rehabilitation was intended to encourage the adoption of an active lifestyle in order to enable participants to live longer at home independently (Hinkka et al. 2006; Ollonqvist et al. 2007), professional practices were described as evolving in order to accommodate clients' voiced needs. In providing comfort treatments and fulfilling clients' social needs, the professionals had, at least partially, to relinquish their objectives of increased functional ability and to adopt more subtle experiential goals. Although positive experiences in social situations are important, the challenging task for physiotherapists remains one of how to integrate older people's needs and active physiotherapy so that clients are meaningfully involved in both the planning and the implementation of the intervention. One of the possible alternatives was found in the account give by the physiotherapists in which older adults were described as experts on their life situation, including everyday living at home (Study II). In this account the professionals aligned their skill alongside the expertise of the older adults and elicited dialogue regarding what was necessary in the intervention. The physiotherapists accepted the uncertainty and incompleteness of their professional knowledge in relation to individual clients when they solicited the lay knowledge of the latter in the negotiation of problems, goals and possible treatments. This approach to the clients resembled the bilateral and empowermental approaches found in previous studies (Kettunen et al. 2001a; Collins et al. 2005).

6.2 Observed interaction between the older adults and physiotherapists during the group sessions

The findings of the third study illuminated the significant role the physiotherapists had in the construction of the group-based exercise sessions in the inpatient rehabilitation for frail adults. The structured group exercise sessions were carried out as instructor-led exercise classes, connoting non-individualised, continuous physical activity often accompanied by music (Study III). It could be argued that highly structured, stationary, low intensity physical activity in a group with encouraging atmosphere provided an opportunity for successful, safe and agreeable exercise even for the frailest participants. This feature realised two important facets of the physiotherapists' account

of older adults as recipients of treatments; namely getting everyone to perform the exercises and providing an agreeable social experience (Study II). The group format has been successfully implemented in various exercise interventions targeted at older adults. The exercise adherence of previously inactive older adults has been shown to increase with team-building and bonding with peers (Estabrooks and Carron 1999). Furthermore, group togetherness has been found to be an effective medium for learning and practising self-regulatory skills in order to sustain independent, long-standing, daily activity at home (Brawley et al. 2000; Rejeski et al. 2003). One of the challenges of these structured exercise sessions, however, was that opportunities were lacking for individual modifications or discussions, resulting in frustration on the part of participants who desired personal adjustments to the tasks.

The guided exercise sessions to a greater extent provided opportunities for individual modifications and personalised feedback that enabled the occasional co-construction of shared meaning of exercises (Study III). According to Martin (2004) these are important first steps in the learning process in physiotherapy, a process in which patients gradually take more an initiating and active role in their performance. The older adults with previously physically active lifestyle were, according to their interview accounts, inspired and their habitual activity strengthened when new exercises were introduced during the group sessions (Study I). The taking up of exercises, however, is more challenging for those older adults who are not accustomed to physical activity as it requires a comprehensive understanding of the activity and its application in everyday living (King et al. 1998). The group sessions, however, were grounded and contextualized in physical rehabilitation, as was shown by the rationales, all of which were from the physiotherapy realm that the physiotherapists provided for the exercises (Study III). Stating the name of the muscle group being activated during a particular exercise does provide information, but this approach has been found less effective than interventions that seek to enhance self-management skills (Bodenheimer et al. 2002).

The circuit training mode offered the greatest scope for independent actions on the part of the older adults (Studies III and IV). The activity was set up to allow adaptability and individual modification. These features were utilised modestly, however, and each participant was expected to perform all of the tasks regardless of their willingness or ability. Moreover, the physiotherapist had to restrict some participants who initiated activities on their own. An explanation for applying restraints was furnished in some of these episodes, with particular emphasis being placed on safety, thereby corroborating previous findings (Ballinger and Payne 2002; Moore 2004) that institutional and professional constraints on clients' own activities are motivated by ensuring that clients perform in a safe manner while in rehabilitation. This institutional mandate for safety, however, appeared somewhat problematic when juxtaposed against older adults' self-activation and autonomy, which were the objects of rehabilitation (Hinkka et al. 2006). The construction of group exercise sessions in this way did not encourage older adults' self-determination, but rather allowed them a submissive position, which has been argued to undermine the primary purpose of rehabilitation (Hart et al. 2005).

The fourth study found that while accepting a submissive position for most of the time, by making initiatives and raising objections, the older adults were attempting to negotiate a more active role during the institutional encounter (Study IV). These active stances taken by clients were to some extent coordinated efforts between peers in line with Goffman's (1959) notion of teams. These team actions by the participants were initiated and sustained by private conversations carried out by peers to coordinate their actions and to solicit assistance from each other. Important self-regulatory features (Rejeski et al. 2003; Martin 2004) were present when the older adults initiated problem solving and shared exercise knowledge and skills with their peers. Moreover, team efforts were directed toward self-determined physical activity. These joint efforts of the older adults during the group sessions enabled them briefly to realise their own ideas and to test their limits. These older adults' meaningful contributions to the issues pertaining to themselves during interaction were, however, challenged by the physiotherapists in the situated praxis of the group exercise sessions. While the older adults' active contribution to the interaction was made more explicit on the occasions when the clients resisted the physiotherapists' orders to halt the activity, these episodes also illuminated the professionals' position in defining the allowed scope of interactional contributions to interaction of the older people. These situations of imposing restraints on older adults' initiatives resembled previous findings (Paterniti 2003; Moore 2004) where the institutional agenda of professionals has caused older adults' initiatives and independent actions to be seen as problematic from the institutional point of view. Although the older people were offered an opportunity for activity, such activity was defined on the physiotherapists' terms. This, it has been suggested, strengthens clients' reliance on the professional prescribing the activity (Baltes and Wahl 1992; Hart et al. 2005) instead of enabling them to build up their own confidence and acquire the skills needed for engaging in independent exercise (Martin 2004).

In conclusion, the findings of this thesis illuminated the challenges that a heterogeneous sample group of community-dwelling older adults as clients created in inpatient rehabilitation. The praxis of physiotherapy in inpatient rehabilitation was complicated not only by those older adults who were perceived as not motivated for active therapy, but also by those clients who initiated independent activities during group sessions. These institutionally troublesome features were greeted by adjusting the intervention in order to provide comfort and nurture and by limiting initiations for safety reasons. From the older adults' point of view the issues found problematic were that the intervention was not adjusted according to their specific needs and that regardless of the intervention, the challenges they faced every day at home remained the same. Consequently, if older adults' independent living at home is to be supported by rehabilitation, instead of viewing older adults' behavior or aspirations as problematic, the praxis of rehabilitation should be reconsidered so as to accommodate older adults' varied and multifaceted needs, and to allow them a more active role during the course of therapy. Older adults have been found to commit to active exercising when the intervention is closely linked to everyday tasks and daily challenges from the start, and when it combines practical and demystified goals with training, all of which support active participation (Rejeski et al. 2003). Furthermore, active physiotherapy, drawing

on these principles after stroke, has been shown to advance older adults' cognitive and physical functional recovery and to support their return to independent living at home (Pyöriä et al. 2007). Older adults' initiatives and independent actions together with joint problem solving are important skills given the challenges of independent community living. The social aspect of group sessions should be more deliberately utilised. Allowing and enabling team efforts by older adults during exercise sessions provide meaningful social interaction and togetherness, which is already a step towards practising necessary skills. The group can be utilised as a medium for learning skills to sustain independent activities at home. Thus, providing older adults with a combination of group activities comprising structured, guided and circuit training sessions and making explicit the link between the activities done during physiotherapy and the tasks of everyday living enhances the likelihood of adoption of these new skills.

6.3 Methodological considerations

In the present study, two types of data were utilised, qualitative semi-structured interviews and video-recorded naturally occurring interactions during group sessions. Although traditionally in qualitative research this kind of data triangulation has been considered a rigorous approach, in recent accounts multiple methods have been viewed as somewhat problematic owing to the practice of merging data from different sources to reveal some underlying objective reality (Sim and Sharp 1998; Angen 2000; Silverman 2001). In this study both interview accounts of the geriatric rehabilitation and the naturally occurring interaction during it were utilised in order to explore a variety of perspectives on realities of rehabilitation. It was assumed that both forms of data are the product of situated encounters. In being invited to share their experiences and thoughts about the rehabilitation, the interviewees were doing something with their accounts, such as assuring the researcher that they were worthy of investment of the rehabilitation or that they were competent professionals. For this reason situated interactions recorded in natural settings are preferred over interviews in discursive psychology (Potter 2005). To reap this advantage, in the present study the interview data were analysed in their own right as specimen (Alasuutari 1995) and, especially in the second study, the focus was not only what the interviewees said but also how they produced their accounts. In the same way the video recordings were approached as locally managed skilful practices focusing on the participants' construction of the event as understandable and accountable during the course of interaction.

Recording naturally occurring talk and activity on video during the group exercise sessions posed some challenges. While the physiotherapists were given the freedom to choose the session for recording, the researcher had to adjust in situ to the spatial and auditory limitations of the site chosen. In line with Jordan and Henderson's (1995) recommendations the video camera was positioned at one end of the room in order to provide consistent coverage of the scene. Even so, in some sessions the seating arrangements and physical activity, which occupied a narrow space, made comprehensive coverage unobtainable with only one camera. In order to compensate for constraint

a supplementary small audiotape recorder was placed in a belt carried by the physiotherapists. Aside from the limits of the technology, another issue to consider is the effect of the camera on the conduct of the participants. Although physiotherapists are increasingly utilising video recordings during the course of therapy interventions (see Talvitie and Pyöriä 2006) this may not be as familiar to the present sample of older adults born in the 1920s and 1930s. It has been suggested, however, that during recent years recording technology has become such a pervasive and everyday feature of peoples' lives in the West that people are habituated to cameras (Hepburn and Wiggins 2007). On the other hand it has been suggested that during detailed analysis of such recordings it will become apparent to the researcher whether or not the presence of the camera was noted by the participants (Jordan and Henderson 1995). In the present study the camera seemed to matter to the participants at the beginning of the sessions, as evidenced by physiotherapists' references to it. There were also a few occurrences of clients referring to the camera or to the operator standing behind it. However, participants quickly habituated to the camera and were absorbed in the exercise, as found in the previous literature (Thornquist 1994b and 2001; Jordan and Henderson 1995; Hepburn and Wiggins 2007), where it has been shown that recordings of situations that have important and practical goals are unlikely to have much influence on the activity, since the participants' attention is elsewhere.

Another issue beyond the immediate effect of the video recording is the selection of group sessions for the present study. In order to avoid their having to make any special arrangements for the purpose of the study, the physiotherapists were asked to choose one ordinary group exercise session scheduled in the rehabilitation programme. In addition, the researcher twice spent several days in each of the rehabilitation facilities observing the courses selected for the study. While the video-recorded sessions were apparently typically constructed, according to the various observations made accross sessions across settings, and the professionals' comments during interviews, it remains unknown how far, if at all, the construction of sessions was modified in the course of the 21 days of the rehabilitation. Thus, with the present study design the long-term temporal processes could not be monitored (Peräkylä 2004).

6.4 Future directions

In the future, longitudinal research designs are needed to investigate more extensive the interaction between clients and physiotherapists during various types of rehabilitation processes and encounters. Such an approach to studying talk-in-interaction has only been adopted earlier in physiotherapy by Kerstin Ek (1990), who explored a patient with 'frozen shoulder' through treatments at an outpatient clinic, and by Ruth Parry (2004a and 2005), who investigated goal setting and performance error management, and by Cathrin Martin (2004), who explored learning as change in interaction. All of these researchers utilised conversation analysis and focused on sequential organization, whereas a discourse analytic approach would extend this analysis of the rhetorical organization of encounters by focusing on the ways versions are constructed in

order to counter alternative versions. The present study suggests that clients derive the meaning they attribute to rehabilitation from their everyday lives. This was also acknowledged by some of the professionals. To acquire an understanding of the actual negotiations which take place during the therapy process regarding the relevance of physiotherapy, its goals and treatments, can provide valuable information about one important aspect of the 'black box' of rehabilitation that is, talk-in-interaction during encounters. Little is known, as yet, about clients' opportunities and resources for bringing up issues of concern and taking an active position in the negotiations that arise during their rehabilitation process. The results of such work will shed light on possible educational needs within the physiotherapy profession. Further research is also needed to explore whether the ways of constructing group exercise sessions in geriatric physiotherapy found in the present study resemble those across a broader range of rehabilitation interventions and settings. Finally, more detailed case studies on clients' meaningful contributions to the interaction during encounters with health professionals during the rehabilitation process are needed.

7 MAIN FINDINGS AND CONCLUSIONS

The main findings of the present study can be summarized as follows:

1. The older adults perceived needs and expectations of rehabilitation varied but overall the meaning they attributed to rehabilitation was constructed on the basis of their experiences of everyday living and its challenges. Rehabilitation was described as enhancing their sense of confidence in everyday living, as failing to meet their needs and as vacation.

2. The physiotherapists described their work with frail older adults from two different perspectives, as one-sided action and as reciprocal action. In the one-way flow position the focus was on treating physical impairments and passive, comfort treatments of socially needy frail clients. In the two-way flow the client was substantially involved in the therapy process.

3. The group exercise sessions were constructed in three different ways, also indicating three distinct patterns of interaction. The overall pattern in all of these was physiotherapist-initiated exercises. The structured exercise sessions were characterised by a highly ordered flow of action orchestrated by the physiotherapist. In the guided exercise sessions there were occasions of individualised guidance and conversations with shared meanings. In the circuit training sessions there was more interactional freedom, with dyadic encounters.

4. The older adults displayed interactional competence and aligned themselves with the physiotherapists' agenda, positioning themselves for taciturn exercising and submissive disagreeing. There were also episodes of client-initiated independent actions where they held their ground and assisted their peers.

In conclusion, the findings of the present study suggest that there is an array of possible interaction patterns during rehabilitation encounters and of the meanings attributed to them. A heterogeneous group of older adults enters a rehabilitation facility with a variety of expectations and perceived needs and interactional competencies. Physiotherapists work according to their own professional frame of reference to satisfy the institutional demands on them and to accommodate to clients' subjective concerns. During the physiotherapy group encounters the participants displayed overall social competence while arranging their actions and talk in a variety of ways. These actions have different functions, and also consequences, in interaction.

YHTEENVETO

Wallin M. **Kotona asuvat vanhukset laitoskuntoutuksessa. Fysioterapeuttien ja asiakkaiden kuntoutuskertomukset ja vuorovaikutus ryhmätilanteiden aikana**. Helsinki: Kela, Sosiaali- ja terveysturvan tutkimuksia 103, 2009. 148 s. ISBN 978-951-669-795-9 (nid.), 978-951-669-796-6 (pdf).

Toimintakyvyltään heikentyneiden vanhusten kotona asumista tukeva kuntoutus on tärkeä kehittämiskohde Suomessa. Yhteiskunnallisen päätöksenteon tueksi tarvitaan tietoa toimintakäytänteistä, jotka ovat tehokkaita ja vaikuttavia. Kelassa aloitettiin vuonna 2002 IKÄ-hanke, joka on kokeellinen tutkimus kuntoutuslaitoksessa toteutetun ryhmämuotoisen geriatrisen kuntoutuksen vaikutuksesta vanhuksen kotona selviytymiseen. Kuntoutusprosessin sisältöä ja toteutusta selvitetään IKÄ-hankkeessa laadullisilla tutkimuksilla. Tämä tutkimus on yksi näistä osahankkeista. Tutkimuksessa kuvataan liikunnallisen kuntoutuksen toteutusta IKÄ-hankkeen kuntoutuskursseilla.

Liikunnallisella kuntoutuksella tarkoitetaan tässä tutkimuksessa ryhmämuotoisesti toteutettua fysioterapiaa IKÄ-hankkeeseen kuuluneilla kuntoutuskursseilla. Geriatrisen fysioterapian tavoitteena on vanhuksen heikentyneen toimintakyvyn paraneminen ja säilyminen harjoittamalla fyysisen toimintakyvyn eri osa-alueita, kuten lihasvoimaa ja tasapainoa. Vanhuksen oma sitoutuminen kuntoutusprosessiin on tärkeää, jotta kuntoutuksen aikana opitut asiat voivat siirtyä osaksi hänen arkeaan kotona. Sitä edistää vanhuksen näkökulman huomioon ottaminen kuntoutuksen tavoitteiden ja toteutuksen suunnittelussa. Tämä tarkoittaa vanhuksen ja fysioterapeutin välistä neuvottelua tärkeäksi koetuista, kuntoutuksessa tavoiteltavista asioista ja konkreettisista tavoista, joilla niihin pyritään. Vanhuksen sitoutumista omaan kuntoutukseensa lisää yhteisesti ymmärretyt ja asetetut tavoitteet sekä mahdollisuus osallistua aktiivisesti oman kuntoutuksensa toteuttamiseen.

Geriatrisen fysioterapian asiakastilanteissa tapahtuvaa vuorovaikutusta ja vanhusten mahdollisuuksia osallistua aktiivisesti omaan kuntoutukseensa on tutkittu vähän. Aikaisemmissa tutkimuksissa on tarkasteltu yleensä yksilöfysioterapiaa käyttäen aineistona asiakkaiden haastatteluja tai nauhoitettujen asiakastilanteita. Ne osoittavat, että vanhuksen mahdollisuudet osallistua tavoitteiden asettamiseen ja terapian aikaisen toiminnan muokkaamiseen ovat vähäiset. Fysioterapian ryhmätilanteiden toteutusta ja niiden aikaista vuorovaikutusta vanhuskuntoutuksesta ei ole aikaisemmin tutkittu.

Tämän väitöskirjatutkimuksen tarkoitus oli selvittää geriatrisen laitoskuntoutuksen liikunnallisen kuntoutuksen toteutumista liikuntaryhmiä ohjaavien ammattilaisten sekä asiakkaiden näkökulmasta. Tutkimuksen keskeisenä tavoitteena oli selvittää liikuntaryhmiä ohjaavien fysioterapeuttien käsityksiä liikuntaryhmien toteuttamisesta ja siitä, miten ne todentuvat asiakkaan näkökulmasta. Tarkoituksena oli myös tutkia toiminnan ja kommunikaation rakentumista liikuntatilanteiden aikana ja asiakkaan aktiivisen osallistumisen mahdollisuuksia.

Tutkittavat valittiin jokaisesta IKÄ-hankkeen kuntoutusta toteuttaneesta seitsemästä eri puolilla Suomea sijainneesta kuntoutuslaitoksesta. Niistä jokaisesta valittiin kaksi kurssia, siten että mukaan tuli sekä taajamissa että haja-asutusalueilla asuvia vanhuksia. Kursseilta valittiin haastatteluihin 31 iältään 66–93-vuotiasta kuntoutujaa, joista jokainen kertoi saavansa apua kotona selviytymiseensä. Kaikki valittujen kurssien liikuntaryhmien suunnittelusta ja toteutuksesta vastuussa olevat fysioterapeutit (n = 11) haastateltiin. Heillä oli työkokemusta 1–20 vuotta. Jokaisesta kuntoutuslaitoksesta videoitiin yksi ryhmäliikuntatilanne (n = 7). Niiden ohjaamiseen osallistui yhdeksän ammattilaista: seitsemän fysioterapeuttia, yksi toimintaterapeutti ja yksi liikunnanohjaaja. Liikuntatilanteisiin osallistui 52 kuntoutujaa, seitsemän miestä ja 45 naista.

Kuntoutujat haastateltiin vuosien 2002 ja 2003 aikana. Ensimmäinen haastattelu tehtiin kuntoutuksen perusjakson aikana kuntoutuslaitoksessa ja toinen kuntoutuksen päättymisen jälkeen vanhuksen kotona. 28 heistä pystyi osallistumaan uusintahaastatteluun. Haastattelujen teemoja olivat jokapäiväinen arki kotona, kuten askareista selviäminen ja muu fyysinen aktiivisuus, ja kuntoutuskokemukset laitoksessa, kuten kuntoutuksen tavoitteet ja sisältö. Uusintahaastattelussa keskusteltiin myös arjen sujumisesta kuntoutuksen jälkeen ja harjoittelun onnistumisesta kotona. Lisäksi keskusteltiin vanhuksen selviytymisestä tulevaisuudessa kotona. Haastattelut äänitettiin ja äänitteet litteroitiin. Ne analysoitiin aineistolähtöisesti ja tapauskohtaisesti selvittäen kunkin haastateltavan kuntoutuskokemukselleen antamia merkityksiä.

Fysioterapeutit haastateltiin valittujen kurssien perusjakson puolivälissä vuonna 2002. He olivat tuolloin tutkineet kyseisille kursseille osallistuneet vanhukset, olleet mukana kotikäynneillä tai saaneet niistä raportin sekä suunnitelleet kurssin liikunnallisen kuntoutuksen osuuden. Haastattelun teemoja olivat fysioterapian konkreettiset tavoitteet ja sisältö ja niiden laatiminen kurssin aikana sekä fysioterapeutin näkemys kuntoutuksen merkityksestä vanhuksille. Nämäkin haastattelut äänitettiin ja litteroitiin. Haastattelut analysoitiin diskurssianalyyttisesti selvittäen, miten fysioterapeutit puhuivat vanhuksista IKÄ-hankkeen kuntoutujina ja miten tämä liittyi kuntoutuksen käytännön toteutuksen kuvauksiin.

Videoaineisto kerättiin valittujen kurssien perusjakson aikana siten, että fysioterapeutit saivat itse valita seurattavan liikuntaryhmän. Mitään liikuntatilanteen sisältöön tai toteutukseen liittyviä ohjeita ei annettu, vaan fysioterapeutilta pyydettiin lupa seurata ja videoida tavallisen IKÄ-hankkeen liikuntaryhmän toimintaa. Videoidut liikuntatilanteet kestivät 45 minuutista tuntiin ja ne toteutettiin yleensä liikuntasalissa. Neljässä liikuntatilanteessa vanhukset harjoittelivat paikallaan pysyen, useimmiten istuen, ja kolme liikuntatilannetta toteutettiin kiertoharjoitteluna. Siinä oli useita eri harjoituspisteitä, joissa jokaisessa tehtiin erilaisia harjoituksia. Jokainen vanhus teki tietyn ajan omaa harjoitustaan ja siirtyi sen jälkeen seuraavaan harjoittelupisteeseen. Tämä vaati useita siirtymisiä harjoittelupisteestä toiseen. Videoaineiston analyysissa kiinnostuksen kohteena olivat ihmisten toimintatavat, joilla he tuottavat sosiaalista todellisuutta, ja aineistoa lähestyttiin etnometodologisesti. Analyysimenetelmänä

käytettiin diskurssianalyysiä, jossa mikrotason vuorovaikutusanalyysin avulla selvitettiin osallistujien liikuntatilanteille antamia merkityksiä ja heidän asemoitumistaan[1] vuorovaikutuksen kuluessa.

Tulokset osoittivat, että vanhusten kuntoutustarpeet ja odotukset kuntoutuksesta olivat erilaisia. Jotkut haastateltavista puhuivat ihanasta kylpylälomasta, toisille kuntoutus oli käytännön ratkaisujen etsimistä arjen ongelmiin sekä fyysistä harjoittelua. Analyysin perusteella vanhusten kuntoutuskokemuksista muodostettiin kolme merkityskategoriaa. *Arjessa pärjäämisellä* vanhukset tarkoittivat kuntoutuksen merkityksen yhteenkietoutumista arjen haasteisiin ja kuntoutuksen avulla löytämiinsä uusiin resursseihin. Kolme kuntoutukseen liittyvää seikkaa toistuivat vanhusten puheessa: 1) He kertoivat saaneensa luottamusta omiin kykyihinsä ja rohkeutta kotona asumiseen. 2) Heidän fyysinen kuntonsa oli kohentunut, joka tuntui ja näkyi konkreettisesti parantuneena fyysisenä toimintakykynä. 3) Vuorovaikutus kuntoutuslaitoksen henkilökunnan kanssa oli ollut merkityksellistä ja rohkaisevaa, kun taas kuntoutuksen *lomaksi* kokeneet vanhukset ottivat kiitollisina vastaan kylpyläloman, joka toimi ikään kuin irtiottona arjen vaikeuksista. Kuntoutuksesta jäi näille vanhuksille miellyttävät muistot, mutta omassa selviytymisessään kodin arjessa he eivät kokeneet tapahtuneen mitään muutosta. *Pettymys kuntoutusohjelmaan* muodostui niille vanhuksille, jotka lähtivät hakemaan kuntoutuksesta apua ja keinoja kokemiinsa arjen haasteisiin ja pettyivät kuntoutusohjelman joustamattomuuteen. He kertoivat turhautuneensa koettaessaan tuloksetta vaikuttaa kuntoutuksen suunnitteluun ja toteutukseen.

Fysioterapeutit puhuivat kahdella eri tavalla. Puheessa vanhuksista *kuntoutuksen vastaanottajina laitoksessa* tuli esille vuorovaikutuksen yksisuuntaisuus: fysioterapeutti on toimija ja vanhus on toimenpiteiden vastaanottaja. Toisten vanhusten kanssa fysioterapeutit keskittyivät vanhuksen fyysisen toimintakyvyn ongelmiin ja niiden ratkomiseen ja toisten vanhusten kanssa heidän sosiaalisiin tarpeisiinsa. Fysioterapeutit kuvasivat jotkut vanhukset mahdollisesti masentuneiksi, yksinäisiksi ja motivoitumattomiksi aktiiviseen harjoitteluun. He kertoivat toimivansa tällaisten vanhusten kanssa asiakaslähtöisesti ja pyrkivänsä tekemään vanhuksen olon mahdollisimman mukavaksi kosketuksen ja läsnäolon välityksellä. Molemmissa tapauksissa fysioterapeutteja askarruttivat vanhuksen tarpeet ”tässä ja nyt”, kuntoutuslaitoksessa ja ammattilaisen näkökulmasta. Fysioterapeuttien puheessa *vanhukset kumppaneina harjoitteluinterventiossa kotona selviytymisen edistämiseksi* heijastui kaksisuuntainen vuorovaikutus ja vanhuksen näkeminen oman elämänsä toimijana. Vanhuksen kodin arki ja voimavarat mutta myös haasteet olivat kuntoutuksen lähtökohtina ja niihin fysioterapeutit hakivat konkreettisia ratkaisuja yhdessä vanhuksen kanssa.

Videoitujen ryhmäliikuntatilanteiden tyypillisimmässä tapahtumassa fysioterapeutti kertoi vanhuksille, mitä ja miten harjoitusta tehdään, ja samanaikaisesti näytti

1 Tilanteille annetut merkitykset tarkoittavat tässä sitä jaettua ymmärrystä, jota osallistujat rakentavat vuorovaikutustilanteessa toistensa kanssa. Asemoitumisella tarkoitetaan tässä niitä vuorovaikutuksen kuluessa muotoutuvia asetelmia ja osallisuuden muotoja, joita ammattilaiset ja kuntoutujat yhdessä rakentavat.

mallisuorituksen, johon vanhukset ”vastasivat” tekemällä liikkeet ohjeen mukaan. Vanhukset harjoittelivat vaitonaisina strukturoidussa liikuntatilanteessa, joka eteni ennakoitavissa olevan kaavan mukaan fysioterapeutin rakentaman harjoituskontekstin sallimissa rajoissa. Vanhukset istuivat selkä- ja käsinojallisissa tuoleissa, jotka fysioterapeutti oli ennalta asettanut puoliympyrän muotoon. Fysioterapeutti antoi jatkuvasti suoritusohjeita ja saattoi myös soittaa musiikkia samanaikaisesti. Liikkeet olivat fyysisesti kevyitä ja helppoja suorittaa. Vanhukset olivat suorituskyvyltään heterogeenisia mutta pystyivät noudattamaan annettuja ohjeita ja suorittamaan liikkeet ilman ongelmia. Fysioterapeutin puheessa olleiden lyhyiden taukojen aikana vanhukset eivät aloittaneet keskustelua tai esittäneet kysymyksiä. Fysioterapeutin lyhyet kysymykset vanhuksille olivat luonteeltaan vanhusten lyhytsanaista myöntymistä tavoittelevia.

Ohjatut liikuntatilanteet rakentuivat fysioterapeutin antamista liikkeiden suoritusohjeista, ja kaikki vanhukset tekivät liikkeet samanaikaisesti. Ohjatuissa tilanteissa fysioterapeutti antoi yleisten ohjeiden lisäksi henkilökohtaisia neuvoja ja apua liikkeiden suorittamisessa. Näiden liikuntaryhmien tavoitteena oli kotiharjoitteluohjelman liikkeiden oppiminen. Yhteisymmärryksen saavuttaminen ohjatuissa liikuntatilanteissa tarkoitti vanhuksille avautuneita mahdollisuuksia jakaa kokemuksiaan harjoittelusta fysioterapeutin kanssa. Vanhukset liittivät puheensa harjoittelusta heille tuttuihin asioihin, kuten fyysisiin tuntemuksiinsa ja kotiaskareisiin. Kun fysioterapeutti osallistui keskusteluun, syntyi yhteisymmärrys harjoittelun tärkeydestä.

Kiertoharjoittelu toteutettiin siten, että fysioterapeutti näytti ensin harjoitteluradan kaikkien suorituspisteiden liikkeet ja sen jälkeen vanhukset jakautuivat ympäri harjoitustilaa tekemään kukin omaa harjoitustaan. Fysioterapeutin määräyksestä kaikki vaihtoivat hetken kuluttua seuraavaan harjoituspisteeseen. Näin jokainen vanhus teki omaa harjoitustaan mutta kaikki vanhukset tekivät kuitenkin samat liikkeet. Kiertoharjoittelu osoittautui heterogeeniselle vanhusryhmälle monella tavoin haasteelliseksi. Suoritusohjeiden antamisesta vanhuksen suorituksen loppuuntekemiseen kului pitkä aika, minkä vuoksi ohjeiden muistaminen oli haasteellista. Lisäksi kiertoharjoittelun suoritusten järjestys ja siirtyminen pisteestä toiseen oli haastavaa sekä vanhuksen muistille että hänen fyysiselle suorituskyvylleen. Myös liikkeet olivat vanhuksille haasteellisia ja he tarvitsivat fyysistä apua suoriutuakseen niistä.

Vanhukset aktiivisina toimijoina kiertoharjoittelussa tarkoittaa erilaisia aktiivisia tapoja osallistua liikuntaryhmien kulkuun. *Hiljaisella harjoittelulla* tarkoitetaan, että vanhus osallistuu tilanteeseen fyysisesti tekemällä määrätyt harjoitukset, mutta verbaalisesti hän osallistuu siihen hyvin vähän tai ei lainkaan. *Vastentahtoisesti suostumisella* tarkoitetaan vanhuksen oman tahdon tai mielipiteen suoraa tai epäsuoraa ilmausta, johon fysioterapeutti vastaa vaatimalla suoritusta alkuperäisen suunnitelmansa mukaan. Vanhus suostuu vaatimukseen, mutta vastentahtoisesti, ja osoittaa sen esimerkiksi ruumiinkielellä. *Sitkeällä yrittämisellä* tarkoitetaan vanhuksen oman tahdon ilmauksia tai omaa tekemistä liikunnan aikana, jonka vanhus vie päätöksen fysioterapeutin kiellosta huolimatta. Vanhus huomioi fysioterapeutin erimielisyyden

mutta ei suostu muuttamaan toimintaansa ja perustelee sitä omalla näkökulmallaan asiaan. Fysioterapeutin kiellot liittyivät usein turvallisuuteen suoritusten aikana. *Kaverin auttamisella* tarkoitetaan vanhuksen aloittamaa spontaania toisen vanhuksen avustamista liikuntaryhmän aikana. Avustaminen saattaa ilmetä toisen vanhuksen kannustamisena ja rohkaisemisena, suoritusohjeiden antamisena tai fyysisenä avustamisena. Vanhukset myös pyysivät toisiltaan apua harjoittelun aikana. Fysioterapeutti salli yleensä kaverin auttamisen, mutta mikäli hän puuttui tilanteeseen, hän perusteli puuttumistaan turvallisuusnäkökohdilla.

IKÄ-hankkeen liikunnallisen kuntoutuksen osahankkeen tulokset avaavat kuntoutuksen käytännön toteuttamiseen näköalan heterogeenisen vanhusryhmän kuntoutukselle tuomiin haasteisiin. Vanhusten motivoimattomuus aktiiviseen harjoitteluun ja toisaalta vanhusten aloitteellisuus ryhmätilanteissa osoittautuivat pulmallisiksi kuntoutuksen arjessa. Fysioterapeutit ratkaisivat näitä haasteita toisaalta tarjoamalla vanhuksille passiivisia mukavuushoitoja, kuten hierontaa, tai toisaalta rajoittamalla heidän tekemistään turvallisuuteen vedoten. Vanhukset pitivät ongelmallisena kuntoutuksen joustamattomuutta, jonka takia kuntoutus ei vastannut heidän tarpeisiinsa eivätkä he saaneet kuntoutuksesta helpotusta arkeensa. Haluttaessa edistää vanhusten itsenäistä kotona selviytymistä kuntoutuksen avulla tulisi heidän toimintansa tai valmiuksiensa kyseenalaistamisen sijasta pohtia sellaisia kuntoutuskäytänteitä, jotka mahdollistaisivat heille tärkeitä ja mahdollisia aktiivisen toiminnan muotoja.

Liikuntaryhmien sosiaalista ulottuvuutta tulisi hyödyntää entistä tietoisemmin. Vanhusten yhdessä harjoittelu toinen toistaan auttaen mahdollisti samanaikaisesti sekä vanhuksille tärkeän sosiaalisen vuorovaikutuksen että fyysisen aktiivisuuden. Vanhusten tekemät aloitteet, aktiivinen tekeminen ja ongelmien ratkaisu yhdessä muiden kuntoutujien kanssa ovat tärkeitä asioita vanhusten itsenäisen kotona asumisen kannalta. Itsenäiseen kotiharjoitteluun tarvittavia taitoja voidaan oppia ryhmätilanteessa. Kun vanhukset saavat osallistua monipuolisesti erilaisiin harjoittelutilanteisiin, kuten strukturoituun, ohjattuun ja kiertoharjoitteluun, ja kun harjoittelu suunnitellaan ottaen huomioon vanhuksen kodin arki, mahdollistuu uusien taitojen siirtyminen osaksi vanhuksen tavallista jokapäiväistä elämää.

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APPENDICES

Appendix 1
Transcript notations

Relative timing of utterances
(2) Timed pause within or between turns (in seconds)
(.) Discernible pause too short to be timed
[ ] Overlaps between utterances
= Contiguous utterances or very rapid move from one utterance to another
Characteristics of speech delivery
Text Word(s) emphasized
TEXT Word(s) spoken loudly
°text° Word(s) spoken very softly or quietly
( ) Unclear words or utterances that cannot be heard
Nonverbal actions
((text)) Clarifying information about physical actions, gazes, laughter

Appendix 2

The Finnish text extract of the original articles:
Article I

Extract 1

V: Se oli kyllä hieno, sillä lailla hieno että huomas kuinka palijo on itellä varoja kun osaa ne oikeen käyttää. Ja se oli minusta tosi hienoa että sielä kannustettiin sitä henkistä kanttia. Että mihin kaikkeen pystyy ku vaan ottaa itteään niskasta kiinni. Sielähän ne oli hirveen hyviä ne keskustelut. Ja, ja sitten ihan uusia semmosia piirteitä tuli kun askartelemassakin käytiin että aha, voi jee – minäkö vanhana vielä opin tämmöst uutta ja tämmöstä nii, sielä sai sitä semmosta selviytymisrohkeutta hirveesti.

Extract 2

V: En. Ei kerta kaikkiaan ku minä pyysin, että jos sais ruuanlaittoapua ja tommosta pyykki-, tai siis siivousapuja sanottiin kylymästi ettei oo mitään mahollisuutta – – sitte lääkäri kysy sielä kuntoutuksessa että; miten teillä se peseytyminen on, mie sanoin että; no kyllä se on melekeen ainoastaan sauna, että meillä on niin pieni vessa että sielä ei oikeastaan pysty muuta kun korkeintaan pärstän pesemään. No mistä te ootta veen saanu sinne, sanoin että; kesällähän sen ottaa pumpulla, se on kaivo ja siitä, talavella sitä ei pysty ottamaan että mä oon sisältä kantanu. Onks pitkä matka, mä sanoin että; se on semmonen neljäkymmentä metriä. Ja sinä oot ite kantanu, mä että; kyllä. Sinul on sepelvaltimovika, sinul on läppävika sydämessä, ja hiljattain olet sairastanu keuhkokuumeen, sinä ET sitä vettä kanna, oikeen painottaen sano. Kysyin; kuka sen sitte kantaa, sano; no joku muu. Että ois kiva tietää kuka se on se joku, no se tullaan järijestämmään sen. Ja on kans järijestyny.

Extract 3

V:Tällä kertaa tuntuu, että paljon kunto on kohentunut – huomattavasti. Piristynyt – Saa sitä jo vanha ihminen, kahdeksankytkuus vuotta. Että toi liikunta on niin suuri tekijä, että kun pääsee liikkumaan, kaikki toimii ja kyllä aina sänkys, sänkyski sitten ni, tääki, tää oli hyvä liike, että hän (fysioterapeutti)opetti täällä, että tuota sänkys, niitä näitä jalkoja, ni ( ) se on kaikki ni jalkasärky, se on täs ja näis varvasluissa, et täs se on semmonen ku se on. Ja moninivelrikko ja se on nyt häipyny vallan.
K: Kun teette tommoisia nilkkapumppausliikkeitä.
V: Nii, joo. Minä joka ilta tehny niitä, ni tänä aamuna sitte ni eikä se oo mikään iso asia, mut se on näköjään aika iso asia, kun tämmösiä vihjeitä on saanu, niin se on suuri asia.
K: Koska säryt vähenee ja pystyy liikkumaan.
V: Joo, joo. Se on monta kertaa, että aamulla ei millään jaksanu nousta, ku tää jalkapohjaki oli niin kipee, ettei kelvannu koskee ja ei se, nyt vallan täällä ollessa parantunu, täälä olles parantunu (nauraa).

Extract 4

K: Et se (alaraajojen lihasvoima) on niinku tän kuntoutuksen aikana parantunu vai jo aikasemmin?

V: Ei ku kuntoutuksen jäl-, aikana siinä mieles et ku tuola oli verkoilla – jään alle verkkoja laittamassa ja siinä avennolla joutu olemaan kyykyssä siinä nii, jos menit polvilleen nii sit et sä päässykkää ylös siitä muuten ku, piti olla joku apuväline.
K: Just, mut nyt pääsee?
V: Nyt pääsee.

Extract 5
K: Jos mietitte kuntoutusjakson merkitystä ihan täällä kotona selviytymiseen, niin mikä siinä teidän mielestä on ollut se anti?
V: No aika hyvä, sitä on saanu tommosta luottoo ite. Että sitä rupes tuntuu, että sitä pärjää – iha omatoimisesti. Niinku siinä, että niijen hoitajienkaan ei tarvi ennää käyvä kahta kertoa, ei sitä kertaakaan. Että uskals kotona ruveta olemaan tällä lailla.

Extract 6
K: Kuka sen keksi, että tämmöisiä asioita siellä harjoittelitte?
V: No, siellä se tuolilta nousu, siellähän sitä esitettiin. Ruvetaan koettaan ensin korkeemmalta tuolilta ja sitten puotettiin tuolia matalammaksi. Siellä se, ja sitten mää sen kyllä siellä esitin, että koajun, ni mä en pääse ylös. Ja siitä se tuli puhheeks ja sitten harjotellaanko ja minä sanon iliman muuta. Ja sitte sitä koitettii ja monena päivänä. Ja aina paremmin ja paremmin meni tää. Kyllä tuli luottamusta. Että, että, sitä pääsee pystyyn.

Extract 7
V: Juu, kyllä tää on hyvää, et tämmönen ihminenki niinku minäki paljo kotioloissa ku oon siel kotona, niin tuota ei sitä niin tuu lähettyä. Kun ei ennää, sanosinko että kun ei ennää jaksa eikä kykene. Niinku tiijät minun ikäni. Niin tuota, tämä on suurenmoesta. Kyllä minä suosittelen tätä tällästä lomanviettoo, että hyvin mielelläni tulen toestekki.

Extract 8
V: Kyllä mä oon ihan mielessäni ajatellu että mä täälä vähän niinkun tunnen henkisesti että on mukavaa, kun on muitakin ihmisiä, ja sitten joku niinkun palvelee ja tekee työtä mun eteeni, hyvinvoinnin saamiseksi.

Extract 9
V: Kyllä mä oon tykänny, ja sitten yks asia on mikä on juur semmosten maksalaatikoitten ja silakkalaatikoitten vastakohta toi juhlapöytä tuola alhaalla ja, sieltä saa hakee sit mieleistänsä ja semmosta vaihtelua mitä ei koskaan oo kotia tuonu. Esimerkiks tommosta niinkun mätiä, ja kaikki tämmöset, niin eihän niitä tuu, ne on kalliita ostaakin ja muutenkaan niitä ei tuu haettua. – Ruoka tääl on aivan ihanteellinen.

Extract 10
V: no tää on ollu ihan mukava kurssi – ihan mukava. Että tää on ihan mukavaa, että minäkin pääsen sieltä yksinäisyydestä vähäks aikaa pois (naurahtaa). Tää on sitte ihan mukava, ihan mukava kun hommasivat minut tänne.

Extract 11
V: Nii mullahan oli sitte oma huone ja sitte ku mä sanoin että; niin tota mää tykkäisin olla ihan yksin, ku mul on kotona aina että sitä täytyy vähä vahtia sillai. Sittehän nyt olin sitte vielä viimeseksi niin ihan yksinäni. Mä nautin kauheesti, oli parveke ja sillai, sai ihan ittekseen olla.

Extract 12
V: No se oli niin hyvä aika – Mä sanoin, että oli – että kyllä se sillä kertaa. Mä huomaan, kun mummut sano minulle, kun mää tulin (takaisin kotiin), että sä oot paljo virkeempi. Mä sanoin, että aatelkaa nyt – sai mennä valmiiseen pöytään – ei ollu mistään mitään huolta. Kaikki huollettiin. Ja sai vielä (nauraa) temppuilla – tehä mitä pysty. Minä sanoin, mutta nyt minä alan taas lässähtää kohta siihen samaan kuntoon. Että ei se niin kauan pitäny mua virkeenä, mutta – (huokaa) – että kyllä se hyvä oli. Ei siitä mittään – –

Extract 13
K: Ymmärränkö oikein, että teillä jäi vähän semmoinen kuva, että te ette pystynyt vaikuttamaan riittävästi siihen, mitä siellä sitten tapahtui, vai?
V: No en, sehän oli se ohjelma laadittu sit sieltä jo valmiiks ja se oli sitte se, mentii aina kellonaikaan saitte ku (naurahtaa) kutsu kuului, että ei siinä oikeestaa enää sitte puhuttu niistä eikä kyselty, että mitä haluais tai toivois.

Extract 14
K: Jos olisitte itte saanu järjestää sen kurssin niinkun itse parhaaks näkisitte, nii mitä olis menny toisin?
V: No kun ne haastattelut (nauraa) eivät minulle merkinneet mitään, ne merkitsi vaan sille haastattelijalle tietysti– niitä olis sitte vähentäny.
K: Joo.
V: Ja niitten tilalle sitte vaikka sitä ihanaa vesijumppaa, ja tämmöstä.

Extract 15
K: Miltä se liikunta tuntu niissä liikuntaryhmissä?
V: No kyllähän se semmosta oottelua oli. Uloski ku lähettii niin tuota – kyllä minun piti lähteä omin päin kävelemään sinne, mie alakanu oottamaan niitä, ja sanoinki niille että kyllä mie menen – menen nyt.

Extract 16
V: – – meil on vähä eritasonen tää meijän ryhmä että, että kyllä mulla pitäs varmasti olla vähän rankempi. Että sillä tavalla ollaan vähä, vähä eri leirissä. Toisilla tuo liikkuminen on niin paljon huonompaa niin, että siinä ei olla ihan tasavertasia.
K: Mites tota, niin sitä et onk sitä sit otettu, ootko kokenu et se on otettu jotenkin huomioon siinä ryhmässä, että ootko saanu?
V: No ei se oo otettu, ei näissä missään sisäjutuissa oo otettu huomioon mutta, mut tuola ulkoliikunnassa niin minä olen tehny yksin sitte vähän pitemmän lenkin, kun mitä nuo, nuo rollaattorin kans liikkuvat sitten ei tee.

Extract 17
V: Mutta ku mä en oon missää tämmösissä kuntoutuslaitoksissa ollu, niin minä jollain tavalla niinku, emmää ol niin tyhmä, että mä en ossoo ite, ite tota ajatella enkä voi aatoksiani julkistaa. Siinä mielessä, ni ohjelmaa niinku tavallaan ylimitotettu näin vanhalle ihmiselle.

Article II

Extract 1
PT 8: Sit jos on jotaki ongelmakohtia, esimerkkinä esimerkiks tämmöne ranteen murtuma, joka on ollu muutama kuukausi takasi ja kipsi saatu pois ja kuitenki liikkuvuus on vähä heikkoo vielä ni. Siihen tietysti mahdolliset kipuhoidot, mobilisoinnit ynnä muut tämmöset asiat ni, ne koetetaan onkii sielt sit kans esiin. Ja tietysti meil on sit syytä ohjata jos on asiakkaalla esimerkiks virtsakarkailuongelma ja se on syy-seuraus jostaki, nii pyritään ohjaamaan sit meijän tälle terapeutille, joka sitte ohjaa jatkos taas eteenpäin ja järjestää kaikki muut vaippa-asiat sun muut tämmöset.

Extract 2
PT 3: Niin tuota sehän sieltä mittaustuloksistahan me esimerkiks nähhään se että mitkä on ne tarpeet. Jos sil on paljon nivelliikkuvuusongelmia, niin me otetaan sillon liikkuvuusharjotuksia ja sitten me lähetään tuota niin viemään sitä kautta. Jos siellä on alaraajojen lihasvoimaheikkouksia lähetään harjottaan sitä. Jos siellä on tasapainoongelmia lähetään harjottaan sitä.

Extract 3
PT 10: Siellä on hyvin monta tämmöstä jotka ovat pelkästään sisällä, yksinäisiä tai sitten ihan tämän muistin ja ulkomuistin kannalta. Et siel on kaikilla niinku joku syy, mut se on se yks ongelma mikä nousee on se liikkumattomuus. Et tuota eivät käy niinku neljän seinän sisältä ulkona. Se on niinku se. Ja sitten toinen on semmonen, semmonen mieliala. Et he ei oikeen koe itseään tärkeeksi, mikä on aika surullista.

Extract 4
PT 4: Ja aina kysytään asiakkaalta itseltään, että mitä hän haluaa. Jos ei halua mitään, taikka tuntee että:" tääkin on ihan hyvä ja olen täällä vaan sitä varten, että on mukavaa", niin ei hirveesti niinku, ei pysty niinku väkisin viemään – –

Extract 5
PT 6: Että jos mietitään jotain fysioterapiaa ja muuta, niin kyllähän tässä sitäkin on. Mut tässä on hirveen paljon sitä kuuntelemista, silittämistä tai jotain muuta. Et me voitais tehä hirveen paljo enemmän hienoja suunnitelmia, hienoja liikkeitä ja kaikkea muuta. Mut se ei sillon lähe siitä asiakkaasta itsestään elikä se ois niinku sitä asiakaslähtöstä tää tämmönen kuntoutus.

Extract 6
PT 9: Mut että mä en niinku, en koe epäonnistuneeni työssä vaikka ne (vanhukset) eivät oliskaan huippukunnossa seurantajaksolla. Et mä aattelen enempi niin päin, että se sen hetkinen tilanne, se tämä päivä missä ne elää, jos ne tällä perusjaksolla nyt kokee niinkun et tää on heiän elämänsä kohokohta, niin miust se on ihan hyvä.

Extract 7
PT 1: Aika lailla semmosta jutustelua, mä ainakin yritän niinku päästä sisälle sen ihmisen kotioloihin. Niin, miten tää ikäihminen päivänsä viettää? Ja sitten tietysti havainnoimalla, haastattelemalla ja vähän mittaamallakin pyritään kartottaa siinä samalla, että mitkä on sen asiakkaan resurssit, kuinka paljon niitä voimia on, mitkä on kaatumisen riskit, minkälaiset on niveliikkuvuudet, kuinka paljon kipuja tulee siinä niinku samalla selville. Ja sitten yritän löytää sieltä asiakkaan kanssa yhessä ne alueet, mihin, ne kriittiset kohat, mihin pitäs keskittyä, ja mitkä on ne suurimmat uhat sitten jatkossa, että jos menee huonompaan suuntaa niin ei enää kotona pärjää.

Extract 8
PT 11: Ja sitte tuota sit me käyään ulkoilemassa sit kokeillaan sauvakävelyä. Ja tuota niin sitte eri noita välineitä niinku tänään kuminauhaa kokeillaan, keppiä kokeillaan et meillä on perustana se että ne on sellasia välineitä jokainen voi hankkia niitä kotiin.

Article III

Extract 1: The client named Taimi sitting on a balance cushion
1 T: Mitä minä teen?
2 PT: Sinä vaan pyörität kankkua siinä tyynyn päällä. ((walks behind Taimi and manually guides the pelvic movements))
– – nine lines omitted where the physiotherapist instructed other clients
3 Sieltä lantio (.) lantion liikettä (.) lannerangalle liikettä ja samalla
4 tasapainoharjottelua. ((facilitates Taimi's pelvic movement manually))

Extract 2: Acting out an imaginary story of a wash at the lake
1 PT: – – No nii. Nyt me ollaan siellä järven rannassa (.) Ja mitäs meijän tekee mieli tehdä (.)
2 No koittaa tietysti onko se niin lämmintä se vesi että me voidaan tehdä se pesu siellä (.) Eli
3 huilutetaas käsiä siellä (.) miltäs se tuntuu?
4 Cs: ((joint laughter))
5 PT: Onko lämmintä?
6 C: On (.) on sopivaa.
7 PT: On sopivaa (.) on sopivaa (.) Erinomaista (.) hyvä (.) No kauhastaan samalla vähä käsiin
8 sitä vettä että päästään alottamaan ne pesuhommat (.) Ensin kädet ja valssi

tietysti
9 sopii sinne ihanaan rantaan (.) ((starts music from cd-player)) Ja lähetään sitten
10 peseen niitä käsiä.

Extract 3: A relaxing prolonged stretching for warm-down
1 PT: – – Käännytään ympäri niin että vasen (.) käsi tulleeki sinne seinälle ja (4)
2 I: Mulla ei tule seinälle.
3 PT: Puolapuille (.) Ja nyt se käsi on taas sen olkapään (1) kohalla (.) sormet
4 näyttää taakse (2) Kurkistettaan oikean olkapään yli taakse – –

Extract 4: Collective review of a home exercise, standing on one leg
1 PT: Joo (.) Kokeillaas sitte sillä huonommalla jalalla (.) vai onko se huonompi
katotaan (.)
2 Ensinnä jalat peräkkäin ja paino molemmilla jaloilla ensinnä (.) hae sieltä että
tuntuu
3 semmoselle mukavalle siinä olla (.) ja sitte ihan hissunkissun viet painon
4 eteen ja nostat takimmaista jalkaa pikkusen ilmaan (.) pidä Anna toinen jalka
5 ((guides Anna's posture manually)) ihan kokonaan maas ja vartalo
6 ihan suorassa (.) Siitä lähet nostaan (.) kokeileppa ny (.)
7 takimmainen jalka nousee pikkusen ylös.
8 A: Eikse nouse?
9 PT: Ei (.) vielä on varpaat maassa.
10 A: Ai kokonaan.
11 PT: Nii kokonaan.
12 A: Mä luulin että kantapää.
13 PT: Ei ei (.) ku kokonaan varpaat ylös kans (.) lattiasta pois.
– – two lines omited where other clients report their success in standing on
one leg.
14 PT: Hyvä (.) noi (.) hyvä ja sitte taas pikkusen ravistele jalkoja (.) Ja käydään
15 sitten taas istahtaan siihen jakkaralle nii huilataan vähä.
16 A: Käsitin vaan että se piti se kantapää nostaa.
17 PT: Mm-m (.) Tuleekohan laiskanläksyä?
18 A: Tulee.

Extract 5: Strength training with an elastic band
1 P: ( ) sammaa liikettä vaen tehhään (.) ni ( ).
2 PT: Nii (.) se se onki ku jos on kovin ykspuoliset ne liikkeet alkaa olla ja siinä
3 kotihommissa niin =
4 P: = Ja sitte jos johonki käy kipiää nii sitte vaa rupiaa
5 jännittämään etteihän tuota pysty [tekemäänkään.]
6 PT: [Nii] Nii ja alkaa vähä niin ku
7 varoa (.) ettei [tee,]
8 P: [Joo.]
9 PT: Että ku päinvaston pitäs pikkase yrittää saada sitä
10 liikettä sinne [takasin]

11 P: [Niin]
12 PT: Mikä tekee kipeät (.) niin se vertyis [se] tilanne hyvissä ajoin
13 (.) ettei kireydy liikaa.
14 P: [Joo]

Exctract 6: In the gym

1 ”PT: Sillai (.) Sitten nämä otat kätteen täältä (3) Nyt täällon raskaat
2 ootappas nuo ollu miehet tekemässä. Otappa nuo poes ( ). ((removes all the weights/resistance))
3 A: ( ).
4 PT: No niin (.) nyt niinku hiihtoliikettä (.) vuorotellen
5 veät niitä taakse (.) Onko liian (.)
6 A: Tämä on liika kevyttä.
7 PT: No niin (.) pistähä (.) Sinä oot hyvin harjotellu (.) Päästä
8 ihan tuonne alas niin minä pystyn laittamaan (.) Noin. ((adds one weight)) Tyhjä.
9 A: Tyhyjää ( ).
10 PT: Ei tarvi (.) kyllä täällä ihan reenataan.

Extract 7: Changing exercise sites in the gym; Hilkka providing peer assistance to Saara and Anna

1 PT: Joo-oo (.) Lähetäänpäs taas vaihtelemaan taas paikkoja.
2 H: Saara siirtyy tuohon [pyllynpyörityspaikalle] ((points to the balance cushion))
3 PT: [Kuhan Paavo piäsöö ensiks] (.) kunhan Paavo ensin
4 pääsee turvallisesti ylös. ((goes to assist Paavo in getting up))
5 A: Miten sie aina [nostit vaan jalkaa?] ((addresses the question to Hilkka))
6 PT: [Ja nyt (.) sie voisit oikeestaan] (.) ((guides Paavo))
7 H: Vaan tänne taakse ((demonstrates the movement to Anna))

Article IV

Extract 1: Group sitting on benches in a circle performing warm-up exercises

1 PT: Hyvä (5) Ja sitte juostaan ihan pikajuoksua (3) HYVÄ! ((nauraa)) Sadan metrin pyrähdys
2 (1) Hyvä! (1) Kopsautapas vastakkaisella kädellä (.)polvea (1) Ja nostat sitä
3 polvea aina ylös ja (5) ja jos se polvi nousee niin korkeelle niin sittenhän sitä voi
4 vaikka kyynärpäällä poksauttaa sitä polvee.

Extract 2: Group standing by the exercise beam and starting the warm-up exercises

1 PT: Hyvä (.) sitte lähes ottaan paikalla askelia (.) jalka nousee (.) polvi nousee kunnolla ylhäälle ( ) Hyvä

2 anna mennä vaan ((looks at Saima)) (.) älä nosta kauheen ylhäälle Saima jos tuntuu että.
3 S: Sehän se vissiin olikin että.
4 PT: Nii (.) pikkusen askelia vaan (.) sen verta et saat sinne vähän jalkapohjaan viestiä et nyt
5 lähetään tekeen liikettä.

Extract 3: Esteri is sitting on a chair resting from the previous exercises

1 PT: Sitte (2) Esteri (1) ((instructor looks at the exercise sites and then turns her eyes back to Esteri))
2 Esteri joutuu nyt ((laughs))
3 E: Minkä? ( ) älä vaan tuu hakkee ( )
4 PT: Tuuppas tänne (7) ((takes Esteri by the hand and leads her towards the exercise site, Esteri follows behind her right shoulder))
5 kävellääs vähä <u>viivakävelyy</u> tosta mut ei sun tartte
6 [tätä nousta ylös] ((points at the ramp))
7 E: [Emmää sitä] (.) mä aattelin et jos mä en nouse sitä =
8 PT: =joo ei tartte (.) <u>joo-o</u>. (.)
9 Mutta (.) pistetääs semmonen lätsä päähän heti (1) ((instructor bends down to pick up a frisbee from the ground and places it on Esteri's head))
10 tuus tänne (3) <u>noi</u> (.)
11 katotaas pysyykö lätsä päässä ((laughs))
12 E: °Ei se pysy°.
13 PT: °Koitas° <u>nostas</u> pääs vähä ylöspäin (.) katotaas millai sit menee ku sä astut vaan niinku
14 ei sun tartte kattookkaan kauheesti alas ku astut vaa toinen jalka toisen eteen (1)
15 <u>hopsan</u> ((laughs as the frisbee falls to the ground and picks it up))

Extract 4: Eila initiated a modification of a resistance tube exercise by doubling the tube, owing to having just broken the tube on her prior turn.

1 E: ( ) paksumpi?
2 PT: <u>Elä</u> laita (.) kyllä se kestää (.) se oli vain (.) se on vaan niin kauan ollu tuo äskeinen
3 hihna siinä [että se on oli aikakin katketa].
4 E: [Mä laitan kaks ( )] ((folds the band over))
5 PT: Laita vaan((naurahtaa)) (.)( ) paitsi että siinä on sitte (.) no ni (.) Elä ihan niin tiukalle (.)
6 ota joo (.) silleen ja sit piät selän suorana että veät vaan kyynärpäitä [taakse]
7 E: [Mä oon]
8 liian pitkällä ( ) tuolilla.

Extract 5: Aarre in the obstacle course

1 PT: Antaa Aarteen (.) tai ton Paulin huilat välillä (.) huilat välillä ja mennääs me. ((looks at Aarre))

2 A: Mä taidan mennä yksin.
3 PT: Sää menet varmaa juu, mä uskon sen (3) Katos nyt tulee tämmönen tiukka paikka. ((holds Aarre's hand))
4 A: Ei mitää.
5 PT: ((nauraa)) (3) Hyvä
6 A: No ni!=
7 PT: =No nii (.) puolet hommast tehty (.) [mennää takasi.]
8 A: [Takasin, nii.]
9 PT: No ni (4) komiasti menee (8) no nii (.) hienoa.
10 A: Kiitoksia palijo. ((continues to hold the instructor's hand, turns towards the instructor and bows slightly towards her as a sign of thanks))
11 PT: Kiitoksia ((laughs)) istuppas sinne sitte

Extract 6: Pauli recruits assistance from Aarre to do the obstacle course and proceeds to the activity regardless of the disapproval of the physiotherapist's, who is preoccupied with providing hands–on assistance to another client, Esteri. A peer, Laura, attends to the proceedings and provides verbal cues.

1 P: Pidäks (.) pidäks mun kädestä kiin jos mä meen ton? ((looks at Aarre and points at the track. Aarre looks at the track and walks over to Pauli, sits down next to him and starts a quiet conversation with him))
– – 13 lines omitted where another client discusses with the physiotherapist
2 PT: Oota (.) mä tuun kävelyttään sua= ((speaks to Pauli, who has already got up and is walking towards the track))
3 L: =Aarre, (.) mes ottaa tota Paulia kädest ((shows Aarre how to take Pauli by the hand)).
4 PT: Hyvä, sitte saat men [huilaamaan.] ((speaks to Esteri as she walks her back to the chair))
5 L: [Pidä kiinni sillai] hyvin sitte että. ((speaks to Aarre))
6 E: Kyllä mä tästä ny [( )]. ((speaks to physiotherapist))
7 PT: [Odottakaas pojat] sit vähä (.)

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